Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 5, 2020	2020_748653_0011	008438-20	Complaint

Licensee/Titulaire de permis

ATK Care Inc.
1386 Indian Grove MISSISSAUGA ON L5H 2S6

Long-Term Care Home/Foyer de soins de longue durée

River Glen Haven Nursing Home
160 High Street P.O. Box 368 Sutton West ON L0E 1R0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ROMELA VILLASPIR (653)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 20, 21, 22, 25, and 26, 2020.

During the course of the inspection, Complaint Log #008438-20 related to provision of basic foot care and baths, the resident's bill of rights, allegation of abuse, medication administration, housekeeping, infection prevention and control, and responsive behaviours, was inspected.

During the course of the inspection, the inspector toured the home, observed the resident, reviewed clinical health records, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the resident, Family Members (FMs), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Assistant Director of Care (ADOC), Director of Care (DOC), and the Administrator.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #005 received preventive and basic foot care services, including cutting of toenails, to ensure comfort and prevent infection.

The Ministry of Long-Term Care (MLTC) received a complaint regarding care concerns related to resident #005. One of the concerns identified was that the resident did not receive basic foot care.

A review of resident #005's health record for bathing, did not identify any documentation that the resident's toenails were checked, cleaned, and trimmed, for an identified period.

A review of resident #005's progress notes indicated their Family Member (FM) requested to have foot care service for the resident. Further review of progress notes, indicated resident #005's FM expressed concern regarding infection in the resident's toes. The ADOC assessed resident #005's feet and noted infection on the toes, and that the toenails were long and required care.

During an interview, ADOC #102 acknowledged that resident #005 did not receive preventive and basic foot care services, including cutting of toenails, to ensure comfort and prevent infection. The ADOC further indicated once it was brought to their attention, they did the basic foot care, and treated the infection. ADOC #102 further indicated subsequently, they had a huddle with the staff on the floor and talked to them about following-up on the resident's toenails. [s. 35. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection, to be implemented voluntarily.

Issued on this 11th day of June, 2020

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.