Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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
Sep 25, 2020	2020_814501_0009	010874-20, 012493-20, 016367-20, 017226-20	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

SUSAN SEMEREDY (501), MOSES NEELAM (762)

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): August 31, September 1, 2, 3, 4, 8, 9, 10. 11, 14, 2020. Off-site interviews took place on September 16, 18, 21, 2020.

The following intakes were completed in this complaint inspection:
Log #010874-20 was related to Residents' Bill of Rights, nutrition and hydration, medication administration, discharge of a resident, accommodation and recreation services;
Log #012493-20 was related to the prevention of abuse;
Log #016367-20 was related to accommodation services, staffing, falls prevention and management, food quality and staffing; and
Log #017226-20 was related to staffing and Family Council.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Recreation Director, Food Service Manager, Environmental Services Manager, registered dietitian, physiotherapist, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSW), recreation aide, administrative assistant, family members and residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Falls Prevention
Family Council
Food Quality
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Responsive Behaviours
Sufficient Staffing
Trust Accounts

During the course of this inspection, Non-Compliances were issued.

3 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's plan of care included clear direction to staff about whether the resident was to receive a specific type of diet.

The resident was not strictly adherent to a specific type of diet. The plan of care was changed, and the resident was to become strictly adherent to this diet and was not to receive certain food items. However, the resident continued to receive these food items for several weeks as the food service department was unaware of the change. The resident continued to receive foods that were not their preference due to a lack of clear direction to staff.

Sources: Resident's progress notes and interviews with the Food Service Manager and Registered Dietitian. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident's plan of care related to medication management provided clear direction.

The resident had requested for their medication to be administered in a certain form which was updated in one section of the plan of care. In another section of the plan of care, direction for administration of medication was not updated. The resident was given and refused medication on two different occasions as the form of administration was not what they had requested. The resident only accepted the medication once it was offered

in the preferred form. Due to the lack of clear direction in the written plan of care, the resident became at risk for refusing their medication.

Sources: The resident's medical record and interview with an RPN. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the care set out in the resident's plan of care related to falls management was provided.

The resident had a history of fall-related injuries and the care plan indicated they were to have interventions in place. Observations indicated the resident had a discontinued intervention in place and two current interventions were not in place. Assistant Director of Care (ADOC) acknowledged the resident's plan of care was not followed. The resident's plan of care not being followed put the resident at risk for possible injury with not having fall management interventions provided as specified.

Sources: The resident's medical record, observations and interviews with ADOC and other staff. [s. 6. (7)]

4. The licensee has failed to ensure that an intervention for the resident was provided as specified in their care plan related to falls prevention and management.

The resident was at risk for falls and the care plan specified that an intervention should be in place. An observation indicated the intervention was not in place. An RN indicated the resident still required this intervention. Not having this intervention in place put the resident at risk for injury.

Sources: The resident's medical record, observation and interviews with an RN and other staff. [s. 6. (7)]

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident and the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all menu items were prepared according to the planned menu during lunch.

Review of the posted menu for lunch indicated one of the choices for the entrée was Havarti sandwich on rye and one of the choices for dessert was mixed berries. During a lunch observation on the third floor the Havarti sandwich was served on regular slices of bread and bananas were served instead of mixed berries. An observation the previous day at lunch indicated bananas were offered as a dessert option as per the planned menu.

The Food Service Manager (FSM) verified the above-mentioned menu items were not prepared according to the planned menu as the bread was not delivered and the mixed berries were not pulled from the freezer in time for meal service. The FSM indicated if they had been informed about the bread from their staff, they would have gone to the store to pick some up.

Planned menu items are approved by a registered dietitian to ensure the menu provides adequate nutrition and variety in keeping with Canada’s Food Guide.

Sources: Observations, posted planned menu (pandemic menu), and an interview with the FSM. [s. 72. (2) (d)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 78. Food service workers, training and qualificationsTraining and qualifications

Specifically failed to comply with the following:

s. 78. (2) The licensee shall cease to employ as a food service worker a person who was required to be enrolled in a program described in subsection (1) if,
(a) in the case of a program referred to in clause (1) (a), the person ceases to be enrolled in the program or fails to successfully complete the program within three years of being hired; or
(b) in the case of a program referred to in clause (1) (c), the registration of the person's training agreement is cancelled, suspended or revoked, or the person fails to receive his or her statement of successful completion of a program under the Apprenticeship and Certification Act, 1998, or certificate of successful completion of a program under the Ontario College of Trades and Apprenticeship Act, 2009, as the case may be,
(i) within three years of being hired, in the case of an apprenticeship program in the trade of Assistant Cook, or
(ii) within five years of being hired, in the case of an apprenticeship program in the trade of Cook or Institutional Cook.

Findings/Faits saillants :

1. The licensee has failed to cease employment of a Food Service Worker (FSW) who failed to successfully complete the Food Service program within three years of being hired.

A review of all food service worker qualifications indicated a FSW did not have a Food Service Worker certificate. An interview with the FSM indicated the FSW was hired in 2014 and since that time had not completed the program.

Food service workers must have training and qualifications to ensure that they are knowledgeable in food preparation in order to mitigate any risks related to food safety.

Sources: Food service worker qualifications and certificates and an interview with the FSM [s. 78. (2)]

Issued on this 1st day of October, 2020

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

Original report signed by the inspector.