Original Public Report

Report Issue Date August 8, 2022
Inspection Number 2022_1022_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
ATK Care Inc

Long-Term Care Home and City
River Glen Haven Nursing Home, Sutton West

Siu F Tang
2022.08.15 15:13:57 -04'00'

Lead Inspector
Eric Tang (529)

Inspector Digital Signature

Additional Inspector(s)
Jack Shi (760), Diane Brown (110). The following inspectors were also present in the inspection: Sharon Connell (741721), and Rita Lajoie (741754).

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 23-24, 27-30; July 4-8, 2022.

The following intakes were inspected:
- Five intakes related to allegations of staff-to-resident abuse and neglect.
- An intake related to the availability of supplies in the home.

The following **Inspection Protocols** were used during this inspection:

- Continence Care
- Falls Prevention and Management
- Food, Nutrition and Hydration
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Responsive Behaviors

INSPECTION RESULTS

WRITTEN NOTIFICATION PLAN OF CARE

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 *[s. 6 (7)]*

1. The licensee has failed to ensure the Personal Support Worker (PSW) followed the resident's plan of care related to their transfer status.

Rationale and Summary

The resident's care plan indicated they required a transfer technique when transferring between surfaces. On one occasion the resident was transferred using an alternate technique utilized by the PSW. When asked, the PSW was unable to rationalize why such technique was used when other support was available at that time.

Failure to follow the resident's transfer status in their plan of care may result in further injury to the resident during their transfer.

Sources: Interviews with the PSW and other staff; Critical Incident System (CIS) Report, home's investigation report; The resident's care plan. (760)

2. The licensee has failed to ensure the care set out in the plan of care is provided to the resident as specified in the plan.

Rationale and Summary

The resident's care plan had indicated a strategy to be implemented by the staff when the resident exhibited a type of response. On one occasion, a nurse had approached the resident preparing for care but the resident had exhibited a response. The nurse continued with delivering the care using an alternate technique with the help of a PSW.

The Behavioural Support Ontario (BSO) lead asserted that the strategy in the resident's care plan was to be followed at all times when care was being delivered. The Administrator had confirmed that the resident's care plan was not followed by the nurse during the interaction and a letter had already been issued to the nurse.

Failure to implement the strategy in the resident's care plan may further trigger resident's response during care.

Sources: CIS Report; The resident's electronic documents, home's internal investigative file; Staff interviews. (529)

WRITTEN NOTIFICATION PLAN OF CARE

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 *[s. 26 (3) 4]*

The licensee has failed to ensure that the resident's plan of care was based on an interdisciplinary assessment of their vision.

Rationale and Summary

On one occasion, the home's video footage indicated that the resident was observed to have not received an intervention in relation to their vision when placed in a room. A recent assessment indicated the resident's vision needs, though the information was not included in their care plan. As per the PSW, the resident had previously required an intervention related to their vision, but other staff (PSWs and an Activation Aide) were unclear on the resident's current vision intervention. The Acting Assistant Director of Care (ADOC) had confirmed the same.

Failure to include the resident's vision in their plan of care resulted in a lack of understanding between staff and that the resident may not have received the intervention required regarding their vision needs.

Sources: Video camera footage; Resident's health record; Staff interviews. (110)

WRITTEN NOTIFICATION RESIDENT RECORDS

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 *[s. 231]*

The licensee has failed to ensure that the resident's written records were kept up to date at all times.

Rationale and Summary

A section of the home's video was reviewed and had captured the resident's condition, and the care from the PSWs and the nurse. The resident's electronic care records were not reflective of the resident's condition nor care received from the on-duty nursing staff. The PSWs and the nurse confirmed that the resident's condition and that their records were inaccurate and not kept up to date at that time.

Failure to ensure the resident's written records were kept up to date might have impacted staff and their ability to provide the required care to the resident.

Sources: Video camera footage; Resident's clinical records; Staff interviews. (110)

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

Central East Service Area Office
33 King Street West, 4th Floor
Oshawa ON L1H 1A1
Telephone: 1-844-231-5702
CentralEastSAO.moh@ontario.ca

WRITTEN NOTIFICATION DIRECTIVES BY MINISTER

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 *[s. 184 (3)]*

The licensee has failed to ensure that a Minister's operational or policy directive was followed related to COVID-19 testing in the home.

Section 8 of the Minister's Directive dated April 21, 2022, stated licensees are required to ensure that the COVID-19 asymptomatic screen testing requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, or as amended, are followed.

Rationale and Summary
A Screener indicated that they would leave a swabbed COVID-19 rapid test in the solution for less than the required time for any swabs they performed on those who entered the home. The Screener then reviewed the manufacturer's instructions and indicated that the swab should be in the solution for at least two minutes. The Infection prevention and control (IPAC) lead confirmed that the swabbed COVID-19 rapid test should be left in the solution for two minutes based on the manufacturer's instructions.

Failure to follow the instructions related to COVID-19 testing may result in false testing outcomes.

Sources: Rapid Antigen COVID-19 test manufacturer's instructions; Staff interviews. (760)

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 [s. 102 (2) (b)]

The licensee failed to ensure that the infection prevention and control (IPAC) standard issued by the director was followed as it relates to ensuring residents received hand hygiene prior to their meals.

Rationale and Summary
During meal observations, some residents were brought into the dining room for meals but did not receive hand hygiene assistance from staff. The IPAC lead stated that residents were to receive hand hygiene from the PSW staff prior to entering the dining room, as per the home's process. The IPAC lead acknowledged that previous audits identified that hand hygiene were not always provided to residents when they entered the dining room for meals.

Failure to provide hand hygiene to residents may result in the further spread of infectious diseases.

Sources: Staff and resident observations; Interviews with the IPAC lead and other staff. (760)

WRITTEN NOTIFICATION RESIDENTS' BILL OF RIGHTS

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 *[s. 3 (1) 1]*

The licensee has failed to ensure that the resident was treated with courtesy and respect and in a way that fully recognized their individuality and respects their dignity.

Rationale and Summary

A review of the home's video footage indicated that the resident was roaming in a common area accompanied by a one-on-one staff where they initiated physical contacts on the resident on multiple occasions preventing them from entering specific home areas.

Both the ADOC and the Administrator confirmed that the one-on-one staff did not treat the resident with courtesy, respect, and dignity in the interactions.

Failure to treat the resident with courtesy, respect, and dignity may cause them to be uneasy and fearful on the floor.

Sources: CIS Report, home's video footage; Staff interviews. (529)

COMPLIANCE ORDER [CO#001] [PREVENTION OF ABUSE AND NEGLECT]

NC#007 Compliance Order pursuant to FLTCA, 2021, s.154(1)2

Non-compliance with: LTCHA, 2007 [*s. 19 (1)]*

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order #001 [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with LTCHA, 2007, s. 19 (1).

The licensee shall:

1). Educate the PSW with a member of the leadership team present on the following:
• The definition of neglect in accordance to the legislation

• The grounds of this compliance order, including the impact and harm this incident has caused to the resident
• The expectations of how and when staff should respond to residents' call for assistance and providing the identified care in an appropriate and timely manner

2). Audit resident-staff communication system and the associate data for a period of two weeks in relation to residents that are assigned and attended to by the PSW. Analyze the audit results and ensure corrective actions are taken to address gaps identified during the audit. Maintain documented records of the audits on-site.

3). Audit the PSW's performance for a period of two weeks, specific to when they provide the identified care to residents, including if they are assigned to the resident's identified care. This audit must be conducted by a registered staff member or someone on the leadership team. Analyze the audit results and ensure corrective actions are taken to address gaps identified during the audit, including any potential gaps in the identified care delivered to the resident by the PSW.

4). Document the education and audits conducted for the PSW, including the date, time, staff members who were involved in the education and any corrective actions. Maintain the records on-site.

5). To immediately develop and implement a safety plan which will include strategies and actions to protect the resident from abuse; maintain a record of the safety plan on-site.

6). To develop and implement a plan to ensure consistent staffing assignment for the resident on specified shifts, when possible, for at least one month upon receiving of this order. Maintain a record of the PSW assigned to the resident.

7). To ensure PSWs from a specific shift are familiar with the resident's plan of care by way of reviewing the resident's plan of care at the start of each shift for one week upon receipt of this order. Maintain a record of the PSWs' review of the resident's plan of care.

Grounds

Non-compliance with: LTCHA, 2007 *[s. 19 (1)]*

1. The licensee has failed to ensure that the resident was not neglected by the PSW.

Rationale and Summary

Section 5 of the Ontario Regulation 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

As per the home's video footage and other resident records, the resident had activated the resident-staff communicating system to seek staff's support. The PSW arrived and deactivated the system without providing the required care to the resident. The resident was left without support for a prolong period of time and caused pain and discomfort to the resident. The resident then exhibited a response in which triggered another resident to call for help. Another PSW arrived and assisted with resident care.

A RN stated that they had overheard the PSW making inappropriate comments about the resident when they had initially deactivated the resident-staff communication system. The staff further asserted that additional support was available to the PSW at that time. An internal investigation was completed and the Administrator confirmed that the PSW was disciplined for neglecting resident care during that interaction.

There was high impact to the resident because they had exhibited signs of pain, discomfort and distress when they were not assisted with the required care. There was moderate risk to the resident, as they were eventually assisted by another PSW but could have led to further injuries had they not been attended by a staff member.

Sources: Interviews with the resident and staff; CIS Report, and home's investigation notes. (760)

2. The licensee has failed to ensure that the resident was not neglected by the licensee or staff.

Rationale and Summary

As per the home's video footage, the resident was left in a communal area for a prolong period of time without receiving the required care as per their plan of care.

Multiple staff interviews with the PSWs and the nurse confirmed the same. The nurse further asserted that the resident was exhibiting a type of response during that time but did not apply the specified interventions as per the resident's plan of care nor seek support from other nursing staff. The resident did not receive the required care until the following shift.

The resident was neglected by the licensee, by way of leaving them without receiving the required support for a prolong period of time. There was a moderate risk to the resident's sense of well-being leaving them unattended in a communal area and would also increase their chance of developing skin breakdown.

Sources: Video camera footage, CIS Report, resident's plan of care; Staff interviews. (110)

3. The licensee has failed to ensure a resident was protected from physical abuse by another resident.

Section 2(1) of Ontario Regulation 79/10 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident."

Rationale and Summary
As per resident records and a housekeeper, a resident was observed to have initiated an action towards a co-resident which resulted in a bodily injury affecting their ability to perform activities of daily living. The resident was immediately assessed by the on-duty nurses and was later sent to a medical facility for additional treatment.

An interview with the Director of Care (DOC) confirmed that this was physical abuse which resulted in an injury.

There was a high impact to the resident as they suffered from a bodily injury that required additional treatment.

Sources: CIS Report, resident electronic documents; Staff interviews. (529)

This order must be complied with by September 9, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West,9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.

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

Central East Service Area Office
33 King Street West, 4th Floor
Oshawa ON L1H 1A1
Telephone: 1-844-231-5702
CentralEastSAO.moh@ontario.ca