Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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Original Public Report

Report Issue Date: January 31, 2023
Inspection Number: 2023-1022-0003
Inspection Type: Follow-Up Critical Incident System
Licensee: ATK Care Inc.
Long Term Care Home and City: River Glen Haven Nursing Home, Sutton West

Lead Inspector	**Inspector Digital Signature**
Eric Tang (529)	Eric Tang Digitally signed by Eric Tang Date: 2023.02.06 12:52:34 -05'00'

Additional Inspector(s)
Marian Keith (741757)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 3 to 6, 10 to 11, 13, 16, 18 to 20, 2023.

The following intake(s) were inspected:

- An intake related to an allegation of resident to resident abuse and neglect.
- Intakes related to a fall with a change in condition.
- A follow-up intake related to prevention of abuse and neglect.
- Intakes related to an allegation of staff to resident abuse and neglect.

The following intakes were completed in this inspection:

An intake was related to responsive behavior; and two intakes were related to falls.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order was found to be in compliance: Order #001 from Inspection #2022_1022_0001 related to LTCHA 2007, s. 19 (1) was inspected by Marian Keith (741757).

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

Falls Prevention and Management
Infection Prevention and Control
Medication Management
Prevention of Abuse and Neglect
Reporting and Complaints
Resident Care and Support Services
Responsive Behaviours
Staffing, Training and Care Standards

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 138 (1) (a) (ii)

The licensee has failed to ensure the medication cart was locked at all times.

Rationale and Summary:

A medication cart was observed to be left unattended and unlocked during an IPAC tour of the home. The Registered Practical Nurse (RPN) acknowledged the cart being unlocked and immediately locked it. The Director of Care (DOC) further asserted that the medication cart was expected to be locked at all times.

There were no further observations of unlocked medication cart during this inspection.

Sources: Observation January 3, 2023, interviews with the RPN and DOC. [741757]

Date Remedy Implemented: January 3, 2023

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b),Infection Prevention and Control (IPAC) Standard Section 9.1 (e).

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control (IPAC).

In accordance with the 'Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022' (IPAC Standard), section 9.1 (e) directs the licensee to ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, Additional Precautions shall include point-of-care (POC) signage indicating that enhanced IPAC control measures are in place.

Rationale and Summary:
A small number of residents were identified with a health condition that required additional precautions during care, but the signages were not placed on their room door on observations made. The IPAC lead and the Director of Care (DOC) confirmed the POC signages were required for the identified residents' rooms.

Failure to post the required signages may increase the risk of transmitting infectious agents between residents.

Sources: home's records, observations, and interviews with the IPAC lead and the DOC. [741757]

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to immediately report suspicion of sexual abuse of the resident.

Rationale and Summary:
A critical incident (CI) report was submitted to the Ministry of Long-Term Care (MLTC) alleging the resident was sexually abused by a staff.

A review of the home's records indicated the identified allegation was discovered on a specific date, but it was not reported to the Director until a later time. The DOC had confirmed the same and asserted that the home was expected to immediately report the matter to the Director.

Sources: CI report, and an interview with the DOC. [741757]

WRITTEN NOTIFICATION: Duty to Protect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that the resident was protected from neglect by staff.

Rationale and Summary:
A CI report was submitted to the MLTC indicating the resident was neglected by a nursing staff.

A review of the home's electronic records indicated that an aspect of resident care was documented as refused or not applicable by a nursing staff as per their plan of care during an identified shift. Further review of the home's internal records indicated the staff did not complete the required care as documented.

The DOC had confirmed the resident was neglected from care during the shift and the identified staff was later dismissed by the home.

Failure to provide the required care to the resident may have increased the risk of discomfort, responsive behaviors, skin breakdown, and infections.

Sources: resident's and home's records, and an interview with the DOC. [741757]

WRITTEN NOTIFICATION: Required Programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee has failed to provide strategies to monitor the resident after their fall.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that the falls prevention and management program provides for assessment and reassessment instruments and must be complied with.

Specifically, staff did not adhere to completing 72-hours post-fall monitoring as per the home's Falls Prevention and Management Program policy.

Rationale and Summary:
A CI report was submitted to the MLTC indicating an interaction occurred between two residents that resulted in a fall.

A review of the home's Falls Prevention and Management Program policy indicated that resident's condition was to be documented in PointClickCare (PCC) every shift for 72-hours after the fall.

A review of the resident's electronic health records was completed, and both the registered nurse (RN) and DOC confirmed the resident's post-fall documentation was not completed on multiple occasions. The DOC further asserted that the nursing staff was expected to document resident's post-fall condition every shift for 72-hour in PCC.

Failure to document the resident's post-fall condition might have impacted staff from monitoring their condition and taking appropriate actions to address their health condition.

Sources: the resident's electronic health records; interviews with the RN and the DOC. [529]

WRITTEN NOTIFICATION: Resident Records

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)

Non-compliance with s. 231 (b) of O. Reg. 79/10 under the Long-Term Care Homes Act, 2007 and s. 274 (b) of O. Reg. 246/22 under FLTCHA.

The licensee failed to ensure that the residents' written records were kept up to date.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 231 (b) of O. Reg. 79/10. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 274 (b) of O. Reg. 246/22 under the FLTCA.

Rationale and Summary Non-compliance with s. 231 (b) of O. Reg. 79/10 under the LTCHA:
1. A CI report was submitted to the MLTC alleging a resident was neglected by the RPN.

A review of the home's documentations indicated that an RPN was alerted to assess the resident due to a suspected change in health condition. An assessment was completed but it was not documented in the resident's electronic health records.

An Assistant Director of Care (ADOC) had also confirmed the same and asserted that all resident assessments were to be documented in the resident's records.

Failure to not having the resident's written records kept up to date might have impacted the interprofessional team's assessment of the resident's condition.

Sources: resident's electronic health records; interview with an ADOC. [529]

Rationale and Summary Non-compliance with s. 274 (b) of O. Reg. 246/22 under the FLTCA:
2. A CI report was submitted to the MLTC indicating an interaction occurred between two residents that led to a fall.

After the occurrence of the interaction the resident's responsive behavior was to be documented on paper for a specific duration. A review of such record indicated a lack of documentation for few hours on a specific date.

The DOC acknowledged the matter and asserted that the nursing staff was expected to fully complete the required resident record during this time.

Failure to complete the resident's care record might hinder staff from understanding the resident's responsive behavior and applying the most appropriate interventions during the identified time period.

Sources: resident's health records; interview with the DOC. [529]