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

Central East District
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Public Report

Report Issue Date: January 27, 2025
Inspection Number: 2025-1022-0001
Inspection Type: Complaint Critical Incident
Licensee: ATK Care Inc.
Long Term Care Home and City: River Glen Haven Nursing Home, Sutton West

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 21-24, 2025
The inspection occurred offsite on the following date(s): January 24, 2025

The following intake(s) were inspected:
•An intake related to the fall and injury of a resident
•An intake related to a complaint of alleged abuse of a resident

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for a resident sets out clear directions to staff and others who provide direct care to the resident in relation to the instructions for falls prevention interventions. A resident's health records provided contradictory instructions regarding falls prevention interventions.

Sources: Health records for a resident, observation, and interviews with staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure the implementation of a strategy to reduce or

mitigate falls as well as the implementation of a specific falls prevention intervention device for a resident.

A resident's health records indicated that the resident was part of the home's falls prevention program. The implementation of a strategy to reduce or mitigate falls did not follow the home's internal process, as intended by the program.

A resident's health records provided instructions for the implementation of a specific fall intervention device. The resident was observed on a certain date without the intervention in place.

Sources: Observation, health records for a resident, interviews with staff.