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
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: April 14, 2025
Inspection Number: 2025-1022-0002
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): April 8 -11, and April 14, 2025

The following intake(s) were inspected:

- An intake related to an injury of unknown origin.
- An intake related to a complaint.

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Documentation

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

A Critical Incident Report (CIR) was received by the Director related to resident #001's injury of unknown cause.

Progress notes reported a change in condition of resident #001 days after sustaining a fall. Interviews with Physiotherapist Assistant (PTA) and late documentation by Registered Practical Nurse (RPN) #104 indicated they had requested the registered nurse's follow up when concerns were identified related to the resident's condition. There were no records related to such during identified shifts.

Sources: CIR, resident's health records, and interviews with PTA and RPN #104.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect was complied with, when a resident reported they were hit by a co-resident.

The Long Term Care Home (LTCH)'s Zero Tolerance of Abuse and Neglect Program indicated adherence to a Zero Tolerance of Abuse policy in which it is the responsibility of all employees to protect the rights of all residents entrusted to their care. Furthermore indicated, no forms of abuse or neglect by any person will be tolerated, and all staff will comply with regulatory requirements for reporting and submitting of alleged, potential, suspected or witnessed abuse.

Progress notes documented by RPN #109 indicated an altercation happened on a specific date, when a resident hit a co-resident. The resident indicated they were hit by a co-resident but no further details were recalled. The Director of Care (DOC) indicated the incident was not escalated to them, and was not reported to the Director.

Sources: Resident's progress notes, and interviews with the resident and DOC.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

The licensee has failed to ensure that an incident or allegation of abuse of a resident was immediately investigated.

A complaint was reported to the Director related to an allegation of abuse of a resident. Progress notes indicated an incident occurred on a specific date and time. It was documented that staff responded to the incident on a specific home area, and the resident reported a co-resident had hit them. The DOC confirmed there were no records related to completion of an internal investigation.

Sources: Resident's health records, and interview with the DOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that an allegation of abuse towards a resident was immediately reported to the Director. On a specific date, it was documented by RPN #109 that a resident was hit by a co-resident. The DOC confirmed the incident was not reported to the Director as required.

Sources: Resident's progress notes, and interview with the DOC.

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
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702