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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jun 25, 2020	2019_664602_0050 (A1)	021325-19	Complaint

Licensee/Titulaire de permis

Land O'Lakes Community Services
12497A Highway 41 PO Box 92 Northbrook ON K0H 2G0

Long-Term Care Home/Foyer de soins de longue durée

Pine Meadow Nursing Home
124 Lloyd Street P.O. Box 100 Northbrook ON K0H 2G0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

Amended by WENDY BROWN (602) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Due to the current emergency orders in place amid the coronavirus pandemic, we will be extending the compliance order #001 issued under c.8, s. 8. (3) from Inspection Report #2019_664602_0050 to October 31, 2020.

Issued on this 25th day of June, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

Amended by WENDY BROWN (602) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 29 and December 3, 2019

The following logs were inspected:

Log #: 021325-19

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Office Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and a family member.

A review of electronic health records was completed. Multiple interview(s) and observations of resident care and services were also conducted. In addition, relevant policies and procedures, Registered Staff Schedule(s), the Nursing Staffing Plan and Nursing & PSW Staffing Services Annual Evaluation documentation were reviewed.

The following Inspection Protocols were used during this inspection:
Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that at least one registered nurse (RN) who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times.

The Long-term Care (LTC) home is a sixty - four (64) bed home divided into two units.

During an interview with Inspector #602 on November 29, 2019, the Administrator #100 indicated that as per the licensee's staffing plan, there should be one RN in the building on each shift. When an RN was not available for a shift, another RN would be called in and overtime would be offered as required. Should the call in procedure and offer(s) of overtime be unsuccessful the licensee directs that each of their four (4) contracted nursing agencies be approached for the provision of RN services. The Administrator indicated that if there was no contract RN available for the shift, then they have scheduled a registered practical nurse (RPN) staff to cover the shift.

Inspector #602 reviewed the registered staff rotation schedule sheets from January 1 to December 1, 2019 with Office Coordinator #106 and the Director of Care (DOC) #101; there were no RN's on duty and present in the LTC home for the following shifts:
1. April 17, 2019 (Day shift - covered by RPN #103)
2. May 29, 2019 (Evening shift - covered by RPN #103)
3. July 20, 2019 (Day shift - covered by RPN#103)
4. July 20, 2019 (Night shift - covered by RPN#103)
5. July 21, 2019 (Day shift - covered by RPN#103)
6. July 21, 2019 (Evening shift - covered by RPN#103)
7. October 11, 2019 (Night shift - covered by RPN#103)
8. October 12, 2019 (Night shift - covered by RPN#103)
9. October 25, 2019 (Night shift - covered by RPN#103)
10. November 8, 2019 (Evening shift 4 hour [1400 to 1800 hours] - covered by RPN#103)

The licensee failed, on ten (10) shifts over an eleven (11) month period, to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff, was on duty and present at all times in the home.

The decision to issue a compliance order was based on the scope and severity of this non-compliance. There was potential for harm since the absence of a Registered Nurse potentially poses a risk to resident safety and affects every resident living in the home. The inspector determined the issue was a pattern as there were a total of 10 shifts with no RN on duty in the home during the 11 month

period reviewed. [s. 8. (3)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

Issued on this 25th day of June, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by WENDY BROWN (602) - (A1)
Inspection No. / No de l'inspection :	2019_664602_0050 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	021325-19 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 25, 2020(A1)
Licensee / Titulaire de permis :	Land O'Lakes Community Services 12497A Highway 41, PO Box 92, Northbrook, ON, K0H-2G0
LTC Home / Foyer de SLD :	Pine Meadow Nursing Home 124 Lloyd Street, P.O. Box 100, Northbrook, ON, K0H-2G0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Margaret Palimaka

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To Land O'Lakes Community Services, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall be compliant with s.8(3) of the LTCHA, 2007.

Specifically, the licensee must ensure that at least one registered nurse who is an employee of the licensee or works at the home pursuant to a contract with the licensee and is a member of the regular nursing staff of the home, is on duty and present at all times.

Grounds / Motifs :

1. The licensee failed to ensure that at least one registered nurse (RN) who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times.

The Long-term Care (LTC) home is a sixty - four (64) bed home divided into two units.

During an interview with Inspector #602 on November 29, 2019, the Administrator #100 indicated that as per the licensee's staffing plan, there should be one RN in the building on each shift. When an RN was not available for a shift, another RN would be called in and overtime would be offered as required. Should the call in procedure and offer(s) of overtime be unsuccessful the licensee directs that each of their four (4) contracted nursing agencies be approached for the provision of RN services. The Administrator indicated that if there was no contract RN available for the shift, then they have scheduled a registered practical nurse (RPN) staff to cover the shift.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Inspector #602 reviewed the registered staff rotation schedule sheets from January 1 to December 1, 2019 with Office Coordinator #106 and the Director of Care (DOC) #101; there were no RN's on duty and present in the LTC home for the following shifts:

1. April 17, 2019 (Day shift - covered by RPN #103)
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9. October 25, 2019 (Night shift - covered by RPN#103)
10. November 8, 2019 (Evening shift 4 hour [1400 to 1800 hours] - covered by RPN#103)

The licensee failed, on ten (10) shifts over an eleven (11) month period, to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff, was on duty and present at all times in the home.

The decision to issue a compliance order was based on the scope and severity of this non-compliance. There was potential for harm since the absence of a Registered Nurse potentially poses a risk to resident safety and affects every resident living in the home. The inspector determined the issue was a pattern as there were a total of 10 shifts with no RN on duty in the home during the 11 month period reviewed. (602)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2020(A1)

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 25th day of June, 2020 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by WENDY BROWN (602) - (A1)

Ontario

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Service Area Office / Bureau régional de services : Ottawa Service Area Office