Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 16, 2019	2019_820130_0006	013236-19, 015176-19	Complaint

Licensee/Titulaire de permis

Rykka Care Centres II GP Inc.
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

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

Pine Villa Nursing Home
490 Highway #8 STONEY CREEK ON L8G 1G6

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

GILLIAN HUNTER (130)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 9 and 10, 2019.

During the course of the inspection, the inspector(s) toured the facility, observed residents, reviewed relevant resident clinical records, investigation notes, critical incident reports, relevant meeting minutes and registered staffing schedules.

This inspection was conducted related to the following intakes:
- Log # 015176-19 related to Resident's Rights;
- Log # 013236-19 related to 24/7 RN staffing.

PLEASE NOTE: This Complaint inspection was conducted concurrently with a Critical incident (CI) inspection #2019_820130_0007.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Interim Director of Care (DOC), the nursing unit clerk, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs) and residents.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 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 :

The licensee has failed to ensure that there was at least one Registered Nurse (RN) who was an employee of the licensee and was member of the regular nursing staff on duty and present at all times.

A complaint log # 013236-19/ IL-68140-HA was submitted to the Director on an identified date in 2019, related to 24 hour nursing care.

Ontario Regulation 79/10, section 45, allowed for exceptions for the requirement of one RN on duty and present at all times, under specific situations, for homes with less 129 beds and for small homes at hospitals.
Pine Villa did not qualify for any exceptions as specified in the regulations.
Pine Villa is a long term care home with a licensed capacity of 41 beds.

At the time of the complaint, the planned staffing pattern for registered nursing staff in the home, for the direct care of residents, was one registered nurse (RN) per shift, as identified on work schedules provided by the home and confirmed by the ED.

In an interview in October 2019, the ED identified that the home did not have a sufficient number of Registered Nurses within the staffing plan to fill all the shifts related to staffing events.

A review of the Schedule Report indicated that on nine occasions over a two month period in 2019, a third party RN was the only RN on duty and on one of those occasion there was no RN on duty.

The ED confirmed in an interview that the need to fill these RN shifts were not the result of emergency situations as outlined in O. Reg 79/10, s. 45(2).

The home did not ensure that there was at least one registered nurse who was an employee of the licensee and was member of the regular nursing staff on duty and present at all times. [s. 8. (3)]

Issued on this 16th day of October, 2019

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

Original report signed by the inspector.