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 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 sions 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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 18, 2016	2016_444602_0007	002440-16	Resident Quality Inspection

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

THE VILLAGE GREEN NURSING HOME
166 Pleasant Drive P.O. Box 94 Selby ON K0K 2Z0

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

WENDY BROWN (602), AMBER MOASE (541), DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): February 22 - 26, 2016 and February 29, March 1 - March 3, 2016

Two Critical Incidents were inspected as part of the resident quality inspection: Log# 003928-15 – medication administered in error requiring transfer of a resident to hospital and Log# 031577-15 - inappropriate touching of a resident by a co-resident.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, Resident Council President, Family Council President, Personal Support Workers (PSW)/Health Care Aides (HCA), Registered Practical Nurses (RPN), Registered Nurses (RN), Administration staff, the Maintenance Supervisor, Housekeeping staff, the Nutritional Care Manager, Dietary staff, the Director of Care (DOC), and the Administrator.

The inspector(s) conducted a tour of the home, observed resident dining, reviewed medication administration including drug destruction practices and drug storage areas, observed resident care, the home's infection control practices including hand hygiene for staff and residents, reviewed resident health care records, food temperature tracking documentation and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **4 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	Legendé 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 a Registered Nurse (RN) is on duty and present at all times.

Village Green is a 66 bed Long-term Care Home in Selby Ontario. In an interview with registered staff on a specified date, Inspector #602 was advised that RN coverage is an issue, with an estimated average of one night or evening shift per month occurring without RN coverage. A subsequent examination of the RN coverage tracking document January 2015 through January 2016 inclusive indicated RN coverage was not provided on fifteen (15) separate evening or night shifts over the thirteen (13) month period; eleven (11) were full shifts, and the remaining four (4) were partially covered.

1. On January 5, 2015 the home did not have a RN from 2300-0700 hours
2. On January 11, 2015 the home did not have a RN from 2300 - 0700 hours
3. On January 15, 2015 the home did not have a RN from 2300 - 0700 hours
4. On February 17, 2015 the home did not have a RN from 2300 - 0700 hours
5. On February 27, 2015 the home did not have a RN for a 4 hour portion evening shift
6. On May 7, 2015 the home did not have a RN from 1500 – 2300 hours
7. On May 8, 2015 the home did not have a RN from 2300 – 0700 hours
8. On August 17, 2015 the home did not have a RN from 1500 – 2300 hours
9. On August 27, 2015 the home did not have a RN for a 3 hour portion of night shift
10. On September 27, 2015 the home did not have a RN for a hour portion of night shift
11. On October 3, 2015 the home did not have a RN from 2300 – 0700 hours
12. On October 4, 2015 the home did not have a RN from 2300 – 0700 hours
13. On December 9, 2015 the home did not have a RN for a 3.5 hour portion of shift (not noted if day, evening or night)
14. On January 4, 2016 the home did not have a RN from 2300 - 0700 hours
15. On January 9, 2016 the home did not have a RN from 2300 - 0700 hours

An emergency or a planned or extended leave of absence by an RN was not the reason for the 15 uncovered shifts, therefore, the exception to the requirement that at least one RN who is both an employee of the licensee and a member of the regular nursing staff is not applicable as per Ontario Regulations 79/10 s. 45 (1)(2).

The staffing plan failed to ensure registered nursing coverage is available when scheduled staff cannot come in to work. A compliance order is warranted given that the scope of the non compliance is widespread as all residents are effected and there is potential for resident harm. [s. 8. (3)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, protocol, strategy or system, that the plan, policy, protocol, strategy or system is complied with.

O. Reg 79/10 s. 68(2)a states that every licensee of a long-term care home shall ensure that the program include the development of and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration.

During Stage 1 of the Resident Quality Inspection forty (40) randomly selected residents are asked about the care and services of the home; residents are asked questions regarding food quality including the temperature at which food is served, it's taste and it's appearance. The following comments regarding temperature were made by residents during this process:

- Resident #037: they served them hot! Didn't taste right.
- Resident #031: 90% of the time it is good, but about 10% of the time it's ice cold.
- Resident #010: tea is sometimes too cold.

- Resident #012: sometimes the eggs are cold in the morning.
- Resident #002: they have a hard time getting the temperature right.
- Resident #017: not always but most of the time (response to question re serving temperatures)
- Resident #004: food comes just barely warm; 2-3 times per week.
- Resident #033: sometimes entrees are cold; about 3 times each week
- Resident #003: Food sometimes too hot or too cool at times

The home's policy # NC-4.10 "Cold Holding" states cold food items such as sandwich filling, salad, dressing and other condiments shall be held between 0 and 4 degrees Celsius (thirty-two(32) and forty (40) Fahrenheit) at all times. Cold food items shall be kept cold with the use of ice packs or ice baths when not in the refrigerator. Cold food items shall be surrounded by ice while outside of cooling unit during dining service. If the temperature of the cold food items rises above 4 degrees Celsius (40 Fahrenheit), it shall be placed back in the refrigerator until temperature returns to below 4 degrees Celsius (40 Fahrenheit).

On February 29, 2016 Inspector #541 observed the lunch meal service set up from the kitchen. Inspector #541 noted a large regular texture green salad sitting on the counter beside the steam table, the minced and puree texture salads were also sitting on the counter. No salad was sitting on ice, nor was any other method used to maintain temperature during meal service.

A subsequent review of the production sheets from February 18-29, 2015 revealed the following 18 cold food temperatures to be above the 40F required by Home policy:

- Egg salad sandwich (regular and puree) 50Fat the start of meal service
- Spinach onion salad (all textures) 50F at the start of meal service
- Turkey and cranberry sandwich (all textures) 50Fat the start of meal service
- Rainbow coleslaw (all textures) 48F at the start of meal service
- Creamy coleslaw (all textures) 45F at end of service
- Romaine salad (all textures) 42-45F at end of service
- Russian chicken salad (all textures) 49F at end of service
- Cheddar cheese 44F at start of meal service
- Egg salad sandwich (all textures) 48-50F at end of service
- Romaine and onion salad (all textures) 46-50F at end of service
- Rainbow coleslaw (all textures) 41-46F at end of service
- Shaved ham on a bun (all textures) 41-44F at start of service

- Mixed green salad (all textures) 42-44F at start of service
- Sweet chili cucumber salad 41F at start of service
- Horseradish 45F at end of meal service
- Tartar sauce 40F at start and end of service
- Tomato and lettuce slices (all textures) 42-44F at start and end of service
- Mixed green salad with dressing 44F at end of meal service

During an interview on February 29, 2016 cook#113 referenced the use of the "Temperature Danger Zone" sheet posted on the wall of the kitchen to determine if foods are at an appropriate serving temperature. Inspector#541 noted that this sheet incorrectly indicates cold foods must be kept below 60F when cold foods must be kept below 40F. Cook #113 was unaware of any corrective action that must be taken when food temperatures are noted to be in the temperature danger zone. Cook#113 indicated that cold foods are left on the counter during meal service as they are not brought out of the fridge until just before service. Cook #113 stated that ice not used to keep items cool. When Inspector#541 asked how temperatures are corrected when they are recorded as being above Policy #NC-4.10's recommended temperatures, cook #113 advised that temperatures are not corrected.

On March 1, 2016 during an interview with Inspector #541 the corporate Nutritional Manager #115 confirmed that the expectation would be for staff to comply with the policy "Cold Holding" to keep food temperatures safe during meal service.

The home failed to comply with policy # NC-4.10 "Cold Holding" in that food and fluids were not served at temperatures considered safe and palatable to the residents. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that policy # NC-4.10 Cold Holding is followed, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

From February 22-24, 2016 Inspectors conducted observations of resident rooms, bathrooms and common areas taking note of any areas of disrepair. Of the 40 resident rooms that were observed, 36 rooms were noted to have scarring on the paint or finish of the door frames as well as scarring, gauges and scrapes along the wooden doors leading to the room and bathrooms.

Of the forty (40) resident bathrooms observed, eleven (11) bathrooms were noted to have damaged, lifting and/or missing toilet seal caulking, and others were noted to have black staining on the floor surrounding the toilet.

On March 1, 2016 Inspector #541 interviewed the home's maintenance manager and asked for a copy of the home's preventative maintenance plan. Inspector #541 was provided with a copy of the home's "Monthly Preventative Maintenance Checklist" which is used to identify areas that require repair. The Inspector asked the Maintenance Supervisor (Main #114) for documentation of the home's preventative plan; this was not provided. Main #114 explained that when a resident moves out, areas of disrepair in the room are repaired at that time but there is no preventative plan to conduct repairs in the home. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings, and equipment are kept clean and sanitary, and are maintained in a safe condition a in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The following findings relate to log #031577-15:

The licensee has failed to ensure identified responsive behaviours were included in the resident plan of care.

On a specified date a resident was observed touching another resident inappropriately. The resident who was being touched indicated that he/she did not want to be touched and staff intervened to separate the residents. The DOC was interviewed and indicated the first resident had attempted to touch the second resident on a previous occasion.

RN #110 was interviewed and indicated she was the charge nurse at the time of the incident. The RN indicated she was unaware the first resident had exhibited any inappropriate sexual behaviours toward other residents. The RN also indicated she usually works nights and it wasn't until her next shift that she became aware this type of behaviour had previously occurred.

PSW's #102 and #103 were both interviewed in regards to the first resident's responsive behaviours. Both indicated the resident was known to make inappropriate sexual comments to staff. PSW #102 further indicated that she was aware the resident attempted to touch the second resident inappropriately in the past and indicated he/she had also attempted to do the same thing to another resident. The PSW stated staff was to monitor the resident for this behaviour and to intervene and redirect as required.

The first resident's plan of care for responsive behaviours was reviewed. The care plan in effect at the time of this inspection indicated the following:

Under "Inappropriate Sexual behaviour", makes inappropriate sexual comments in the dining room to staff-set limits for acceptable behaviour and ask resident not to talk like that as it is not acceptable. The RAP summary was also reviewed and had no documentation in regards to responsive behaviours.

The resident plan of care failed to identify the resident's inappropriate sexual behaviours involving co-residents and interventions to address or reduce the risk to the residents. [s. 26. (3) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure resident #023's plan of care accurately reflects this resident's responsive behaviours, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The following findings relate to log #003928-15:

The licensee has failed to ensure drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

On a specified date, a resident was administered medication by a RN; the dosage administered was significantly higher than the ordered dosage. The DOC was interviewed and indicated the home had started using the electronic version of medication administration records (e-MAR) one month earlier. According to the e-MAR, the resident's medication orders had not recently changed and this RN had previously administered resident medication.

When the home investigated the incident, the home determined the instructions were displayed such that the dosage could be misinterpreted. According to the DOC, the RN indicated she knew she had made an error as soon as the medication was given and notified the physician. The incident resulted in the resident being sent to hospital for treatment and monitoring overnight. According to the DOC, the RN was required to review the College of Nurse medication administration practices. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure medications are administered in accordance with instructions specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, 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. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The following findings relate to log #031577-15:

The licensee has failed to ensure the home's abuse policy was complied with.

Sexual abuse is defined by the LTCHA, 2007 as any non-consensual touching, behaviour or remarks of a sexual nature directed towards a resident by a person other than a licensee or staff member.

On a specified date a resident was observed touching another resident inappropriately. The resident who was being touched indicated that he/she did not want to be touched and staff intervened to separate the residents.

The RN indicated she had not observed the incident but had been advised by one another staff of the occurrence. The RN stated she spoke to first resident and directed him/her not to go near the other resident. The RN could not recall if she spoke with the other resident about the incident. The RN stated she was unaware that the first resident had previously exhibited inappropriate sexual behaviours toward this resident and other co-residents, and did not notify the manager on call to discuss the incident or consider

reporting the incident as a sexual abuse.

The home's abuse policy, #AM-6.9, Zero Tolerance of Abuse, under Procedure, indicates any person who has reasonable grounds to suspect that a resident has been abused is obligated by law to immediately report the suspicion and the information upon which it is based to the Director, Home's Administrator or manager on call. Each incident of abuse shall be considered and immediately reported to the Ministry of Health and Long Term Care (MOHLTC) by telephone. The MOHLTC was first notified of the incident the day after it had occurred.

Reporting Incidents of abuse, #AM-6.9, under "Policy" indicates the resident's family or substitute decision maker will be notified immediately after the alleged, suspected or witnessed incident of abuse has been reported. The resident's family were contacted by the home in regards to the incident the day after it had occurred.

This inspector asked to review the home's 2015 abuse training records which indicated not all staff received annual training in the area of abuse. The DOC confirmed the training is provided on line and that all staff is given the full year to complete the required training. The DOC agreed not all staff completed the required abuse training during 2015.

In accordance with the home's abuse policy #AM-6.9, under "Employee Training and Retraining Requirements", all staff, students and volunteers of the home upon hire and at a minimum of annually thereafter shall review:
Zero tolerance of abuse and neglect policy,
Power Imbalance between staff and residents,
Duty to report, Mandatory Reporting Procedures ,
Reporting incidents of abuse and abuse reporting guidelines table,
Investigation Procedures,
Abuse and Neglect Decision trees.

The home failed to ensure their abuse policy was complied with during the management of this incident of resident to resident abuse. [s. 20. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 75. Nutrition manager

Specifically failed to comply with the following:

s. 75. (3) The licensee shall ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities. O. Reg. 79/10, s. 75 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure the Nutrition Manager is on site at the home working in the capacity of Nutrition Manager for the minimum number of hours per week without including any hours spent fulfilling other responsibilities.

The Administrator informed Inspector #602 upon entering the home that the Nutritional Care Manager (NCM) is currently off on leave and hours are being covered by a corporate NCM and assistance from another Omni NCM. Inspector #541 asked for a copy of the NCM hours worked since December 2015 when the home's NCM went on leave.

The Administrator confirmed the home has 66 beds therefore the home is required to have a NCM on-site for 21.12 (21 hours) per week.

Inspector #541 reviewed the NCM hours worked on-site from December 2015 to February 2015 :

December 13 to 19th, 2015: No NCM on-site
December 20-26, 2016: 8 hours
December 27-January 2, 2016: No hours
January 3-9, 2016: No hours
January 17-23, 2016: 8.5 hours
January 24-30, 2016: 16 hours
January 31-Feb 6, 2016: 11 hours
February 7-13, 2016: No hours
February 14-20, 2016: 5 hours
February 21-27, 2016: 6 hours

During an interview March 1, 2016 with Inspector #541 the Administrator confirmed the NCM hours noted are the only on-site hours worked.

The home failed to ensure there is a NCM on-site at the home for a minimum of 21 hours per week. [s. 75. (3)]

Issued on this 18th day of March, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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 Homes Division
Long-Term Care Inspections Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	WENDY BROWN (602), AMBER MOASE (541), DARLENE MURPHY (103)
Inspection No. / No de l'inspection :	2016_444602_0007
Log No. / Registre no:	002440-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 18, 2016
Licensee / Titulaire de permis :	Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner 2020 Fisher Drive, Suite 1, PETERBOROUGH, ON, K9J-6X6
LTC Home / Foyer de SLD :	THE VILLAGE GREEN NURSING HOME 166 Pleasant Drive, P.O. Box 94, Selby, ON, K0K-2Z0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LINDA PIERCE

To Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

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 prepare, submit and implement a plan for achieving compliance to 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. The plan shall also include all recruiting and retention strategies. This plan is to be submitted in writing by May 2, 2016 to Wendy Brown at 347 Preston Street, 4th floor, Ottawa, Ontario, K1S 3J4 or by fax at 613-569-9670.

Grounds / Motifs :

1. The licensee failed to ensure that a Registered Nurse (RN) is on duty and present at all times.

Village Green is a 66 bed Long-term Care Home in Selby Ontario. In an interview with registered staff on a specified date, Inspector #602 was advised that RN coverage is an issue, with an estimated average of one night or evening shift per month occurring without RN coverage. A subsequent examination of the RN coverage tracking document January 2015 through January 2016 inclusive indicated RN coverage was not provided on fifteen (15) separate evening or night shifts over the thirteen (13) month period; eleven (11) were full shifts, and the remaining four (4) were partially covered.

1. On January 5, 2015 the home did not have a RN from 2300-0700 hours
2. On January 11, 2015 the home did not have a RN from 2300 - 0700 hours
3. On January 15, 2015 the home did not have a RN from 2300 - 0700 hours
4. On February 17, 2015 the home did not have a RN from 2300 - 0700 hours

5. On February 27, 2015 the home did not have a RN for a 4 hour portion evening shift
6. On May 7, 2015 the home did not have a RN from 1500 – 2300 hours
7. On May 8, 2015 the home did not have a RN from 2300 – 0700 hours
8. On August 17, 2015 the home did not have a RN from 1500 – 2300 hours
9. On August 27, 2015 the home did not have a RN for a 3 hour portion of night shift
10. On September 27, 2015 the home did not have a RN for a hour portion of night shift
11. On October 3, 2015 the home did not have a RN from 2300 – 0700 hours
12. On October 4, 2015 the home did not have a RN from 2300 – 0700 hours
13. On December 9, 2015 the home did not have a RN for a 3.5 hour portion of shift (not noted if day, evening or night)
14. On January 4, 2016 the home did not have a RN from 2300 - 0700 hours
15. On January 9, 2016 the home did not have a RN from 2300 - 0700 hours

An emergency or a planned or extended leave of absence by an RN was not the reason for the 15 uncovered shifts, therefore, the exception to the requirement that at least one RN who is both an employee of the licensee and a member of the regular nursing staff is not applicable as per Ontario Regulations 79/10 s. 45 (1)(2).

The staffing plan failed to ensure registered nursing coverage is available when scheduled staff cannot come in to work. A compliance order is warranted given that the scope of the non compliance is widespread; effecting all residents and there is potential for resident harm. (602)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 02, 2016

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 or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 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:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 18th day of March, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Wendy Brown

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