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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 28, 2013	2013_270531_0003	O-000414-13	Critical Incident System

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9

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

SUSAN DONNAN (531)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 26th, and 27th, 2013

During the course of the inspection, the inspector(s) spoke with with a Personal Support Worker, a Registered Nurse, the Clinical Care Coordinator, the RAI Coordinator, Maintenance Manager, Director of Care and the Administrator.

During the course of the inspection, the inspector(s) toured/observed the outside garden area including the surrounding fence, reviewed resident health care records including notes made by specialized outside agencies, and reviewed maintenance records regarding fence repair.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 O.Reg 79/10, s. 9. Doors in a home

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Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg. 79/10 s. 9 (1) 1 ii.

Resident #1 had a diagnosis of a cognitive impairment and was an identified elopement risk. On a specified date he/she was given unsupervised access to the outside garden area. A short time later, the home was alerted that Resident #1 had been found in a neighbouring yard.

In an interview with the Maintenance Manager, he advised the fence had heaved over the winter which resulted in an open area at the base of the fence which was approximately eighteen feet by eighteen inches high. It was determined that Resident #1 had left the garden area through the opening.

Several staff were interviewed and stated it was the home's practice to remove the alarm to the garden area at certain times of the day to allow residents to safely wander unsupervised in a secure area. Staff was unaware of the opening in the fence at the time of the incident. The fence was repaired following the incident.

As a result of the fence being in disrepair, the garden area could not be utilized as a secure area. According to the legislation, a door leading to the outside of the home into an unsecured area must be kept locked and be equipped with a door access control system that is kept on at all times. [s. 9. (1) 1. ii.]

2. The licensee has failed to comply with O.Reg. 79/10 s. 9 (2).

In an interview with the Administrator, she confirmed the home does not have a written policy for the doors leading to the secure outside area for when the doors must be locked and unlocked to permit or restrict unsupervised access to the area by residents. [s. 9. (2)]

Issued on this 28th day of November, 2013

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

Susan Klemmer