**Ministry of Health and Long-Term Care**
Long-Term Care Homes Division
Long-Term Care Inspections Branch

**Ministère de la Santé et des Soins de longue durée**
Division des foyers de soins de longue duree
Inspection de soins de longue durée

# Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

| | ☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public** |
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| **Name of Director:** | Wendy Lewis |
| **Order Type:** | □ Amend or Impose Conditions on Licence Order, section 104<br>□ Renovation of Municipal Home Order, section 135<br>x Compliance Order, section 153<br>□ Work and Activity Order, section 154<br>□ Return of Funding Order, section 155<br>□ Mandatory Management Order, section 156<br>□ Revocation of Licence Order, section 157<br>□ Interim Manager Order, section 157 |
| **Intake Log # of original inspection (if applicable):** | |
| **Original Inspection #:** | 2018_610633_0016 |
| **Licensee:** | Revera Long Term Care Inc.<br>5015 Spectrum Way, Suite 600<br>Mississauga ON L4W 0E4 |
| **LTC Home:** | The Village Seniors Community |
| **Name of Administrator:** | Dylan Subject |

**Background:**

Ministry of Health and Long-Term Care (MOHLTC) Inspectors #633 and #728 conducted an inspection at The Village Seniors Community (LTC Home) on the following dates: August 13, 14, 15, 16, 17, 20, 21, 22, and 23, 2018 (Inspection #2018_610633_0016).

This inspection was a follow-up inspection at which time three intake logs (001638-18, 001639-18, 001640-18) were inspected. Non-compliance identified from Inspection # 2018_610633_0017, which was completed concurrently during this inspection, related to s. 8(3) of the *Long-Term Care Homes Act, 2007*. Information and findings from the concurrent inspection were incorporated into the inspection report for this inspection (Inspection #2018_610633_0016) and the present Director's Order.

During the inspection, the Inspectors found that the Licensee, Revera Long-Term Care Inc. (The Village Seniors Community or the Licensee) failed to comply with subsection 8(3) of the Long-Term Care Homes Act, 2007 (LTCHA). Based on the non-compliance, the Inspector issued a compliance order.

Specifically, pursuant to s.153(1)(a) of the LTCHA, Inspectors #633 and #728 issued the following:

Compliance Order #001 relates to LTCHA s.8 (3) and reads as follows:

The licensee must be compliant with LTCHA 2007, c. 8, s. 8 (3).

Specifically, the licensee must 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

This order must be complied with by: December 31, 2018.

Following a review of the Inspector's Order by the Director, the Inspector's order has been substituted with the Director's Order below.

| **Order:** | CO #001 |
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To Revera Long-Term Care Inc. you are hereby required to comply with the following order(s) by the date(s) set out below:

**Pursuant to:**
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:**
The licensee must be compliant with LTCHA 2007, c. 8, s. 8 (3).

Specifically, the licensee must 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

**Grounds:**
The Licensee has failed to comply with Compliance Order (CO) #001 from inspection 2017_363659_0022 served on December 21, 2017, with a compliance due date of February 28, 2018.

The Licensee was ordered to ensure that at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff of the LTC home was on duty and present at all times unless there was an allowable exception to this requirement.

The Inspectors conducted a review of the registered staff schedules from June 2 to August 24, 2018. The schedules showed that from June 15 to August 13, 2018 (180 days), there was no Registered Nurse (RN) present and working in the LTC home on the following shifts:

- On June 23 from 1500 to 2300 hours;
- On July 1 from 1500 to 1900 hours;
- On July 9 from 1800 to 2300;
- On July 26 from 2300 to 0700 hours.

During a concurrent Critical Incident inspection (2018_610633_0017), the Inspectors reviewed a CI report that stated Registered Practical Nurse (RPN) #110 did not administer Resident #009's medication on a date in September 2017.

The Inspectors reviewed the LTC home's investigation records, Resident #009's plan of care, which included their paper chart, and conducted staff interviews with Registered Practical Nurses (RPNs) #109 and #110, who were present when the medication error occurred.

RPNs #109 and #110 stated that there was a miscommunication between the two RPNs and the medication should have been clarified with the Physician and given to Resident #009 before the standardized administration times at the LTC home. There was no Registered Nurse (RN) working at the time of this incident for the RPN's to consult with.

During interviews with the Inspectors, RPNs #109 and #110, the DOC and the Executive Director (ED) all confirmed that there was no RN present and working at the LTC home on that date in September 2017 when the medication error occurred.

The LTC home’s staffing plan, titled "Revera, The Village Seniors Community LTC Staffing Plan 2018" stated that there was to be at least one Registered Nurse (RN) that did not include the Director of Care (DOC) on duty and present at all times.

On August 16, 2018, the DOC said that they were on-call and agreed that there was no RN present and working in the LTC home for the identified shifts.

The application of factors taken into account under subsection 299(1) of Ontario Regulation 79/10 requires a Compliance Order to be issued. I have assessed the severity of the non-compliance as a level 2, which means that there was minimal harm or potential for actual harm to Resident #009 and all residents in the LTC home as a result of not having an RN on duty and in the LTC home on the identified shifts. The scope is assessed as a level 3, as the non-compliance (not having an RN present) can have a negative impact on all residents in the LTC home. The compliance history is a level 4, as the Licensee has previous and ongoing non-compliance with this same requirement under the *LTCHA*.

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| **This order must be complied with by**: | December 31, 2018 |

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

**Health Services Appeal and Review Board**
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

**Director**
c/o Appeals Clerk
Long-Term Care Inspections Branch
347 Preston Street, 4th Floor, Suite 420
Ottawa ON K1S 3J4
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.

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| Issued on this 11th day of December 2018. | |
| Signature of Director: | |
| Name of Director: | Wendy Lewis |

Version date: July 27, 2016