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

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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
Jan 9, 2019	2018_750539_0014	011646-17, 022076-17, 008889-18	Critical Incident System

Licensee/Titulaire de permis

ATK Care Inc.
1386 Indian Grove MISSISSAUGA ON L5H 2S6

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

The Fordwich Village Nursing Home
3063 Adelaide Street Fordwich ON N0G 1V0

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

VALERIE GOLDRUP (539)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 3, 4, 5, and 6, 2018.

The following intakes were completed in this Critical Incident System Inspection:

Log #011646-17- related to Critical Incident Report (CIS) submission 0995-000007-17 for an injury with a significant change in condition.

Log #022076-17- related to Critical Incident Report (CIS) submission 0995-000010-17 for an injury with a significant change in condition.

Log #008889-18- related to Critical Incident Report (CIS) submission 0995-000003-18 for an injury with a significant change in condition.

During the course of the inspection the Inspector toured the home and observed resident care, services and activities. Clinical records and plans of care for identified residents were reviewed. Also, relevant documents were reviewed including but not limited to the home's documentation and procedures as related to the inspection.

During the course of the inspection, the inspector(s) spoke with with the Administrator/Director of Care (Administrator/DOC), the Administrative Assistant (AA), a Registered Nurse, a Registered Practical Nurse/Resident Assessment Instrument Coordinator (RPN/RAI Coordinator), Registered Practical Nurses (RPNs), Personal Support Workers, and residents.

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

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **1 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 :

1. The licensee has failed 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 unless there was an allowable exception to this requirement (see definition/description for list of exceptions as stated in section 45.(1) and 45.1 of the regulation).

During the inspection, an Inspector became aware that the home was pre-scheduling Registered Practical Nurses (RPN) to work as the charge nurse with no Registered Nurse (RN) in the building.

The registered staff schedule, for a specified time, was reviewed with the Administrator/ Director of Care. They confirmed that four of the 126 shifts or three percent of shifts during that time period had been pre-booked with a RPN because there was no available RN to work the scheduled shifts.

Three RPNs stated that they had been pre-booked to work as the charge nurse when there was no RN available to take the shifts.

An RPN stated that this had happened in the summer as well, so that the RNs could take vacation and to avoid burn out of the RNs. They stated there was a shortage of RNs available to take all the shifts.

An RN stated that there had been times when they were unable to cover all shifts with a RN.They would try to get two RNs to work 12 hour shifts if that occurred or they used a RPN.

The Administrator/Director of Care stated that they were short one full time RN and were attempting to hire a full time RN and a part time RN. When short a RN they would pre-book a RPN to work as the charge nurse.

The licensee failed 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 unless there was an allowable exception to this requirement (see definition/description for list of exceptions as stated in section 45.(1) and 45.1 of the regulation). [s. 8. (3)]

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 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), to be implemented voluntarily.

Issued on this 10th day of January, 2019

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

Original report signed by the inspector.