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
Apr 8, 2019	2019_486653_0007	003652-19	Complaint

Licensee/Titulaire de permis

Markhaven, Inc.
54 Parkway Avenue MARKHAM ON L3P 2G4

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

Markhaven
54 Parkway Avenue MARKHAM ON L3P 2G4

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

ROMELA VILLASPIR (653)

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): February 19, 20, 21, and 22, 2019.

During the course of the inspection, complaint log #003652-19 related to resident #001's plan of care, continence care and bowel management, and staffing in the home, had been inspected.

A Compliance Order related to s. 8 (3) of the Long-Term Care Homes Act, S.O. 2007, identified in concurrent inspection report #2019_486653_0006 (Log #001634-19) will be issued in this report.

During the course of the inspection, the inspector reviewed a broadcast program's video episode, the home's staffing schedule and staffing plan, residents' clinical health records, staff training records, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Agency Registered Nurses (Agency RNs), Human Resources Manager (HRM), Administrative Nursing Co-Ordinator (ANC), and the Director of Care (DOC).

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Personal Support Services
Sufficient Staffing
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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	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 had 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 in the home at all times.

According to LTCHA, 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.

According to LTCHA s. 8 (4), During the hours that an Administrator or Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations.

A) The following evidence was identified under inspection report #2019_486653_0006 (Log #001634-19):

The home had submitted a Critical Incident Report (CIR) to the Director on an identified date and time, for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIR indicated resident #009 sustained an identified injury and was sent to the hospital on an identified shift.

An interview with Registered Practical Nurse (RPN) #113 confirmed they had worked on the identified shift and was in-charge of the building. The RPN further indicated there was no Registered Nurse (RN) present in the building, however, the Director of Care (DOC) was available by telephone.

B) The Ministry of Health and Long-Term Care (MOHLTC) received complaint log #003652-19 related to concerns reported in an identified broadcast program's video episode. The concerns were related to staffing, inaccessible call bell, long wait times for toileting, and circumstances surrounding resident #001's passing.

A review of the identified broadcast program's video episode that had a duration of 22 minutes and 26 seconds, revealed the home's funding was cut by the province forcing it to lay off a night nurse.

A telephone interview with the home's Administrative Nursing Co-Ordinator (ANC) stated

the last time there was an RPN working during the night shift with an RN was on December 17, 2017, and afterwards only an RN worked in the home during the night shift.

A review of the home's staffing schedule and daily roster report from December 18, 2017, up to February 18, 2019, indicated there had been no RN present in the building during the night shift for the following dates:

-April 15, 2018;
-August 8, 14, 18, 28, 2018;
-September 7, 13, 2018;
-October 9, 2018;
-November 8, 9, 16, 2018;
-January 20, 2019.

A telephone interview with RPN #113 indicated there was no RN present in the building when they had worked the night shift on April 15, 2018, and January 20, 2019. RPN #113 further indicated the DOC was available by telephone, and the RPN recalled the DOC may have come in the building at 0100hrs or 0200hrs, but did not stay for the entire shift.

A telephone interview with RPN #127 indicated there was no RN present in the building when they had worked the night shift on November 9, and 16, 2018, and that they were the only registered staff in the building at the time. RPN #127 further indicated the DOC was not present in the building but was available by telephone.

A telephone interview with RPN #126 acknowledged they had worked the night shift on August 8, 14, 28, September 7, 13, October 9, and November 8, 2018. RPN #126 further indicated the DOC was present in the home when they had worked the above mentioned night shifts. The RPN stated they had seen the DOC in their office, and when the DOC did rounds. When asked by the inspector at what capacity the DOC worked at during those nights, RPN #126 stated at the capacity of a DOC.

A telephone interview with RPN #128 indicated they could not recall working on the night shift of August 18, 2018.

A telephone interview with the home's Human Resources Manager (HRM) confirmed there was no RN present in the building in the above mentioned dates based on the

staffing schedule. The HRM further indicated the night shifts were offered to part-time RNs who had fewer than ten shifts, and the home had offered double shifts and overtime to the other RNs. The home also utilized agency RNs, and if the agency was unable to supply an RN, the home scheduled an RPN to work and the DOC would be physically present in the building. [s. 8. (3)]

2. According to LTCHA, 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.

According to O. Reg. 79/10, s. 45 (1) (2) ii, The following are the exceptions to the requirement 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, as required under subsection 8 (3) of the Act:

2. For homes with a licensed bed capacity of more than 64 beds and fewer than 129 beds,

ii. in the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this Regulation fails to ensure that the requirement under subsection 8 (3) of the Act is met, a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if,

A. the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone, and

B. a registered practical nurse who is both an employee of the licensee and a member of the regular nursing staff is on duty and present in the home. O. Reg. 79/10, s. 45 (1).

According to O. Reg. 79/10, s. 45 (2) In this section, "emergency" means an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home.

A review of the home's staffing schedule and daily roster report from December 18, 2017, up to February 18, 2019, revealed that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was

not on duty and present in the home at all times, except as provided for in the regulations:

i) Former full-time night RN #131 took a float day on September 3, 2018, and part-time night RN #132 took a float day on December 18, 2019. A follow-up telephone interview with the HRM on March 26, 2019, at 1205hrs, indicated each staff was entitled to four float days a year, and that float days were pre-booked. As per the staffing schedule and the HRM, an agency RN worked in the home on the above mentioned night shifts, and was the only registered staff present in the building for the entire shift.

ii) Part-time night RN #132 was coded on vacation on the monthly schedule report, and had been replaced by an agency RN on the daily roster report for the following night shifts:
-March 13, and 18, 2018;
-August 19, and 24, 2018;
-September 1, and 2, 2018;
-December 23, 2018.

iii) An e-mail correspondence from the HRM received by the inspector indicated former full-time night RN #131 was no longer working in the home as of October 9, 2018. Current full-time night RN #133 was offered the position, and accepted the position on October 26, 2018, however, RN #133 could not start working at the home until November 21, 2018. As per the staffing schedule and the HRM, an agency RN worked in the home on the following night shifts, and was the only registered staff present in the building for the entire shift:
-October 10, 12, 15, 16, 17, 18, 20, 21, 22, 24, 25, 26, 29, 30, 31, 2018;
-November 1, 3, 4, 5, 7, 12, 13, 14, 15, 18, 19, 21, 2018.

A telephone interview with the DOC indicated if the home was short of RNs and an RPN had to work the night shift, the DOC would come in the building, stay in their office and do their work, as well as do rounds in the building. When asked by the inspector at what capacity they work in when they come to the home when there was no RN, they indicated always within the DOC capacity. During a follow-up telephone interview, the DOC acknowledged that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was not on duty and present in the home at all times, except as provided for in the regulations.

As per record reviews and staff interviews, the licensee had failed to demonstrate to the

inspector that the home had satisfied s. 8 (3) of the Act, wherein one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations. The details surrounding the above mentioned night shifts that were covered by the agency RNs did not meet the exceptions to the requirement.

The licensee had failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff was on duty and present in the home at all times. [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. 45. 24-hour nursing care — exceptions

Specifically failed to comply with the following:

s. 45. (1) The following are the exceptions to the requirement 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, as required under subsection 8 (3) of the Act:
1. For homes with a licensed bed capacity of 64 beds or fewer,
i. a registered nurse who works at the home pursuant to a contract or agreement between the nurse and the licensee and who is a member of the regular nursing staff may be used,
ii. in the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this Regulation fails to ensure that the requirement under subsection 8 (3) of the Act is met,
A. a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone, or
B. a registered practical nurse who is a member of the regular nursing staff may be used if the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is

available by telephone. O. Reg. 79/10, s. 45 (1).
2. For homes with a licensed bed capacity of more than 64 beds and fewer than 129 beds,
i. in the case of a planned or extended leave of absence of an employee of the licensee who is a registered nurse and a member of the regular nursing staff, a registered nurse who works at the home pursuant to a contract or agreement with the licensee and who is a member of the regular nursing staff may be used,
ii. in the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this Regulation fails to ensure that the requirement under subsection 8 (3) of the Act is met, a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if,
A. the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone, and
B. a registered practical nurse who is both an employee of the licensee and a member of the regular nursing staff is on duty and present in the home. O. Reg. 79/10, s. 45 (1).

Findings/Faits saillants :

1. The licensee had failed to comply with r. 45 (1) (2) ii of O. Reg. 79/10, whereby the licensee did not meet the exceptions to the requirement that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times as required under subsection 8 (3) of the Act.

According to O. Reg. 79/10, s. 45 (1) (2) ii, The following are the exceptions to the requirement 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, as required under subsection 8 (3) of the Act:

2. For homes with a licensed bed capacity of more than 64 beds and fewer than 129 beds,
ii. in the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this Regulation fails to ensure that the requirement under subsection 8 (3) of the Act is met, a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if,

A. the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone, and

B. a registered practical nurse who is both an employee of the licensee and a member of the regular nursing staff is on duty and present in the home. O. Reg. 79/10, s. 45 (1).

A telephone interview with the home's ANC stated the last time there was an RPN working during the night shift with an RN was on December 17, 2017, and afterwards only an RN worked in the home during the night shift. When asked by the inspector how they covered night shifts when the regular RN staff was unable to come to work, the ANC stated they would go through the home's wizard system and if they could not find anyone from their staff to work, they would call agency. The ANC further indicated that it was not a practice of the home to book a regular RPN staff to work with the agency RN on a night shift, however, the DOC would be available by telephone to support the agency RN, and would also pop in and out of the building.

A review of the home's staffing schedule and daily roster report from December 18, 2017, up to February 18, 2019, indicated an agency RN had worked in the building during the night shift for the following dates when the home's regular RN staff had called in sick:

-January 6, and 15, 2018;
-February 28, 2018;
-March 9, 2018;
-March 23, 2018, the regular RN had a family emergency;
-April 10, 14, and 24, 2018;
-May 3, and 8, 2018;
-July 12, 2018;
-August 9, 2018;
-November 17, 2018;
-January 5, 11, 16, 23, and 26, 2019.

A telephone interview with the HRM confirmed an agency RN worked in the home on the above mentioned night shifts without an RPN who was both an employee of the licensee and a member of the regular nursing staff, on duty and present in the home.

A telephone interview with Agency RN #122 who had worked four night shifts at Markhaven in 2018, indicated they were the only registered staff in the building and there was no RPN working with them during the night shift. Agency RN #122 further indicated the DOC was available by telephone and would come in at times, but did not stay for the entire shift.

A telephone interview with Agency RN #123 who had worked seven night shifts at Markhaven in 2018, indicated they were the only registered staff in the building during the night shift. RN #123 further indicated the DOC was accessible through the phone and would only come if they were called. The Agency RN stated they do not recall the DOC being present in the home when they had worked on the above mentioned night shifts.

A telephone interview with Agency RN #124 who had worked ten night shifts at Markhaven in 2018, indicated they were the only registered staff in the building during the night shift. The Agency RN further indicated the DOC was available by telephone, and would come in the building from time to time.

A telephone interview with Agency RN #125 who had worked twelve night shifts at Markhaven in 2018, indicated they were the only registered staff in the building working during the night shift. RN #125 further indicated the DOC was off-site, available by telephone, and accessible at any time. The Agency RN recalled there were two night shifts the DOC had come to the home, and just popped in and out of the building.

Separate telephone interviews with Personal Support Workers (PSWs) #109 and #130 who worked full-time night shifts indicated in 2018, there was only one registered staff scheduled to work at night even if it was an agency RN. PSW #109 further indicated the DOC would sometimes be present in the building working in their office when an agency RN worked during the night shift.

An interview with the DOC acknowledged the home had a bed capacity of 96 beds, and further indicated when an agency RN worked during the night shift, the DOC would be on-call, and would pop in and out of the building. A follow-up telephone interview with the DOC acknowledged that the exceptions to the requirement of s. 8 (3) of the LTCHA had not been complied with when an RPN who was both an employee of the licensee and a member of the regular nursing staff was not on duty and present in the home when the agency RN worked the above mentioned night shifts. When asked by the inspector why the home had not booked an RPN to work with the agency RNs, the DOC indicated it had not been past practice.

The licensee had failed to comply with r. 45 (1) (2) ii of O. Reg. 79/10, whereby the licensee did not meet the exceptions to the requirement that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times as required under subsection 8 (3) of the Act. [s. 45. (1) 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 that the following exceptions to the requirement 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, as required under subsection 8 (3) of the Act: 2. For homes with a licensed bed capacity of more than 64 beds and fewer than 129 beds, i. in the case of a planned or extended leave of absence of an employee of the licensee who is a registered nurse and a member of the regular nursing staff, a registered nurse who works at the home pursuant to a contract or agreement with the licensee and who is a member of the regular nursing staff may be used, ii. in the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this Regulation fails to ensure that the requirement under subsection 8 (3) of the Act is met, a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if, A. the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone, and B. a registered practical nurse who is both an employee of the licensee and a member of the regular nursing staff is on duty and present in the home, are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee had failed to ensure that the care set out in the written plan of care was provided to the resident as specified in the plan.

The MOHLTC received complaint log #003652-19 related to concerns reported in an identified broadcast program's video episode. The concerns were related to staffing, inaccessible call bell, long wait times for toileting, and care concerns related to resident #001.

A) A review of resident #001's written plan of care and Treatment Administration Record (TAR) indicated they had an identified medical device that required an identified care provision, and had to be signed off by the registered staff on each shift. Further review of resident #001's TAR from an identified time period revealed a missing signature on an identified date and shift.

B) A review of resident #001's physician's digiorder form revealed on an identified date, a registered staff received a telephone order from the Nurse Practitioner (NP) for an identified care provision and to document the care on PCC. A review of resident #001's TAR from an identified time period indicated the aforementioned order to provide the identified care. A review of resident #001's PCC notes did not identify documentation that the identified care had been provided to the resident on an identified date and time.

A telephone interview with RPN #119 confirmed they had worked on the identified shift and stated they could not recall providing resident #001 the identified care as required. RPN #119 further indicated if there was no signature on the TAR, it meant they did not do the care.

C) A review of resident #001's written plan of care directed staff to ensure that an identified device was within their reach when in bed.

A review of the identified broadcast program's video episode revealed clips showing that the identified device was placed in an area that was not within resident #001's reach.

During separate interviews, RPNs #100, #118, and RN #117 confirmed they were the staff members seen in the clips from the identified video episode, with another PSW. The three registered staff indicated it was at the time when they had found resident #001 in their bedroom. When asked by the inspector where the identified device was located based on the clips shown, all three registered staff acknowledged the device was not within resident #001's reach. RPN #118 and RN #117 further indicated that staff were supposed to ensure that the identified device was within resident #001's reach when they were in bed. The three registered staff acknowledged that the care set out in resident #001's written plan of care was not provided to the resident as specified in the plan.

An interview with the DOC acknowledged the above mentioned information from record reviews, staff interviews, and the identified broadcast program's video episode. When asked by the inspector about the home's investigation, the DOC indicated they felt it was inconclusive because they did not have the entire video to work with, and that the episode only presented clips of the whole video. The DOC insisted they did not have enough evidence to make a comment on this particular care concern, but indicated resident #001 needed to have the identified device within reach. The DOC further acknowledged that based on the records presented, RPN #119 did not provide the care set out in resident #001's written plan of care on the identified shift. The DOC further indicated not following the resident's plan of care put their health status at risk.

The licensee had failed to ensure that the care set out in the written plan of care was provided to resident #001 as specified in the plan.

The severity of this issue was determined to be a level 3 as there was actual risk to the resident. The scope of the issue was a level 1 as it related to one of three residents reviewed. The home had a level 4 compliance history as they had ongoing non-compliance with this section of the LTCHA that included:
-Voluntary Plan of Correction issued February 1, 2017 (#2017_334565_0002);
-Voluntary Plan of Correction issued October 4, 2017 (#2017_650565_0011).

Non-compliance was found under LTCHA, 2007, s. 6 (7), within inspection report #2018_486653_0014 and a compliance order was issued to the home on October 30, 2018. It had been confirmed through follow-up inspection #2019_486653_0005 that the non-compliance found under LTCHA, 2007, s. 6 (7) had been addressed and complied by the home since the non-compliance occurred in 2017. Therefore, a written notification will be issued within this inspection #2019_486653_0007. [s. 6. (7)]

Issued on this 9th day of April, 2019

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

Original report signed by the inspector.

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

Ministère 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 soins de longue durée

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ROMELA VILLASPIR (653)
Inspection No. / No de l'inspection :	2019_486653_0007
Log No. / No de registre :	003652-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 8, 2019
Licensee / Titulaire de permis :	Markhaven, Inc. 54 Parkway Avenue, MARKHAM, ON, L3P-2G4
LTC Home / Foyer de SLD :	Markhaven 54 Parkway Avenue, MARKHAM, ON, L3P-2G4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Mike Bakewell

To Markhaven, Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Ministère 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

Order # / Ordre no : 001

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

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 must be compliant with s. 8 (3) of the Long-Term Care Homes Act (LTCHA).

Specifically, the licensee shall do the following:

1. 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.

2. Evaluate and update the home's back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work, and when there are registered staff vacancies.

3. Educate the management team, administration staff, and all registered nursing staff on the requirement of s. 8 (3) of the LTCHA, and the exceptions to the requirement as provided for in the regulations.

4. Keep a record of all activities carried out under items #1 to #3 above.

The above mentioned documentation shall be made available to the inspector upon request. This order shall be complied no later than June 24, 2019.

Grounds / Motifs :

1. The licensee had 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 in the home at all times.

According to LTCHA, 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.

According to LTCHA s. 8 (4), During the hours that an Administrator or Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations.

A) The following evidence was identified under inspection report #2019_486653_0006 (Log #001634-19):

The home had submitted a Critical Incident Report (CIR) to the Director on an identified date and time, for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIR indicated resident #009 sustained an identified injury and was sent to the hospital on an identified shift.

An interview with Registered Practical Nurse (RPN) #113 confirmed they had worked on the identified shift and was in-charge of the building. The RPN further indicated there was no Registered Nurse (RN) present in the building, however, the Director of Care (DOC) was available by telephone.

B) The Ministry of Health and Long-Term Care (MOHLTC) received complaint log #003652-19 related to concerns reported in an identified broadcast program's video episode. The concerns were related to staffing, inaccessible call bell, long wait times for toileting, and circumstances surrounding resident #001's passing.

A review of the identified broadcast program's video episode that had a duration of 22 minutes and 26 seconds, revealed the home's funding was cut by the province forcing it to lay off a night nurse.

A telephone interview with the home's Administrative Nursing Co-Ordinator (ANC) stated the last time there was an RPN working during the night shift with an RN was on December 17, 2017, and afterwards only an RN worked in the home during the night shift.

A review of the home's staffing schedule and daily roster report from December 18, 2017, up to February 18, 2019, indicated there had been no RN present in the building during the night shift for the following dates:

-April 15, 2018;
-August 8, 14, 18, 28, 2018;
-September 7, 13, 2018;
-October 9, 2018;
-November 8, 9, 16, 2018;
-January 20, 2019.

A telephone interview with RPN #113 indicated there was no RN present in the building when they had worked the night shift on April 15, 2018, and January 20, 2019. RPN #113 further indicated the DOC was available by telephone, and the RPN recalled the DOC may have come in the building at 0100hrs or 0200hrs, but did not stay for the entire shift.

A telephone interview with RPN #127 indicated there was no RN present in the building when they had worked the night shift on November 9, and 16, 2018, and that they were the only registered staff in the building at the time. RPN #127 further indicated the DOC was not present in the building but was available by telephone.

A telephone interview with RPN #126 acknowledged they had worked the night shift on August 8, 14, 28, September 7, 13, October 9, and November 8, 2018. RPN #126 further indicated the DOC was present in the home when they had worked the above mentioned night shifts. The RPN stated they had seen the DOC in their office, and when the DOC did rounds. When asked by the inspector at what capacity the DOC worked at during those nights, RPN #126 stated at the capacity of a DOC.

A telephone interview with RPN #128 indicated they could not recall working on the night shift of August 18, 2018.

A telephone interview with the home's Human Resources Manager (HRM) confirmed there was no RN present in the building in the above mentioned dates based on the staffing schedule. The HRM further indicated the night shifts were offered to part-time RNs who had fewer than ten shifts, and the home had offered double shifts and overtime to the other RNs. The home also utilized agency RNs, and if the agency was unable to supply an RN, the home scheduled an RPN to work and the DOC would be physically present in the building. (653)

2. According to LTCHA, 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.

According to O. Reg. 79/10, s. 45 (1) (2) ii, The following are the exceptions to the requirement 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, as required under subsection 8 (3) of the Act:

2. For homes with a licensed bed capacity of more than 64 beds and fewer than 129 beds,

ii. in the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this Regulation fails to ensure that the requirement under subsection 8 (3) of the Act is met, a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if,

A. the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone, and

B. a registered practical nurse who is both an employee of the licensee and a

member of the regular nursing staff is on duty and present in the home. O. Reg. 79/10, s. 45 (1).

According to O. Reg. 79/10, s. 45 (2) In this section, "emergency" means an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home.

A review of the home's staffing schedule and daily roster report from December 18, 2017, up to February 18, 2019, revealed that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was not on duty and present in the home at all times, except as provided for in the regulations:

i) Former full-time night RN #131 took a float day on September 3, 2018, and part-time night RN #132 took a float day on December 18, 2019. A follow-up telephone interview with the HRM on March 26, 2019, at 1205hrs, indicated each staff was entitled to four float days a year, and that float days were pre-booked. As per the staffing schedule and the HRM, an agency RN worked in the home on the above mentioned night shifts, and was the only registered staff present in the building for the entire shift.

ii) Part-time night RN #132 was coded on vacation on the monthly schedule report, and had been replaced by an agency RN on the daily roster report for the following night shifts:
-March 13, and 18, 2018;
-August 19, and 24, 2018;
-September 1, and 2, 2018;
-December 23, 2018.

iii) An e-mail correspondence from the HRM received by the inspector indicated former full-time night RN #131 was no longer working in the home as of October 9, 2018. Current full-time night RN #133 was offered the position, and accepted the position on October 26, 2018, however, RN #133 could not start working at the home until November 21, 2018. As per the staffing schedule and the HRM, an agency RN worked in the home on the following night shifts, and was the only registered staff present in the building for the entire shift:
-October 10, 12, 15, 16, 17, 18, 20, 21, 22, 24, 25, 26, 29, 30, 31, 2018;

-November 1, 3, 4, 5, 7, 12, 13, 14, 15, 18, 19, 21, 2018.

A telephone interview with the DOC indicated if the home was short of RNs and an RPN had to work the night shift, the DOC would come in the building, stay in their office and do their work, as well as do rounds in the building. When asked by the inspector at what capacity they work in when they come to the home when there was no RN, they indicated always within the DOC capacity. During a follow-up telephone interview, the DOC acknowledged that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was not on duty and present in the home at all times, except as provided for in the regulations.

As per record reviews and staff interviews, the licensee had failed to demonstrate to the inspector that the home had satisfied s. 8 (3) of the Act, wherein one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations. The details surrounding the above mentioned night shifts that were covered by the agency RNs did not meet the exceptions to the requirement.

The licensee had failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff was on duty and present in the home at all times.

The severity of this issue was determined to be a level 2 as there was potential for actual harm/risk to residents living in the home. The scope of the issue was a level 3 as it related to all residents living in the home. The home had a level 2 compliance history as they had one or more unrelated non-compliance in the last 36 months. (653)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 24, 2019

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 8th day of April, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Romela Villaspir

Service Area Office /
Bureau régional de services : Central East Service Area Office