Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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 soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l’inspection	Log # / Registre no	Type of Inspection / Genre d’inspection
Jun 1, 2017	2017_520622_0016	008345-17	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

HEATH HEFFERNAN (622), 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): May 23, 24, 25, 26, 30, 2017

The following Critical Incident Log was inspected:
Critical incident Intake log #010086-17 related to alleged resident to resident abuse

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), a Physician, Registered Nurses (RN), Registered Practical Nurses (RPN), RAI Coordinator, Personal Support Workers (PSW), Resident and Family Council members, residents and families.

Also during the course of the inspection, the inspectors conducted a tour of the home, observed resident care, observed medication administration, reviewed health records, observed and reviewed infection control practices, observed resident to resident interactions, reviewed resident and family council minutes and applicable licensee policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

- **2 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	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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident’s money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Re: Log # 010086-17

A Critical Incident Report (CIR) was submitted to the Director on a specified date and time several hours after an alleged incident of resident to resident abuse occurred. The CIR indicated on a specified date at a specified time, resident #018 allegedly abused resident #024. The PSW intervened removing resident #018 from the area of resident #024.

During an interview, RN #114 indicated if a staff member witnesses or suspects abuse has or may take place, it is to be reported immediately. RN #114 also said the registered nurse in charge is to call the manager who is on call and do the critical incident system report. RN #114 stated that staff can contact the Ministry of Health and Long Term Care (MOHLTC) to report however, normally this was something the DOC would do unless the DOC was absent.

During an interview, PSW #112 stated on a specified date she witnessed the alleged abuse of resident #024 by resident #018. PSW #112 said she documented the incident on paper and handed it to the RN within a specified time frame following the incident.

During an interview, RN #115 indicated on a specified date she was aware that an incident of alleged abuse of resident #024 by resident #018 had occurred. RN #115 further indicated she placed the written concern of the alleged resident to resident abuse in the DOC’s mail slot and communicated the incident during morning report the next day. Furthermore, RN #115 stated she did not contact the MOHLTC.

During an interview, the DOC stated she received a written statement of alleged resident to resident abuse in her mail slot and notification of the incident in the morning report on a specified date. Furthermore, the DOC indicated the incident which occurred on a specified date was considered to be abuse. The DOC further stated the home filed the on line report late with the MOHLTC on a specified date as RN #115 had not reported the incident of alleged resident to resident abuse immediately. [s. 24. (1)]

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 a person who has reasonable grounds to suspect that abuse of a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

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:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

On a specified date during the initial tour of the home, inspector #622 observed the following;
1) The maintenance manager’s office door located in a corridor behind the dining room was unlocked. Tools, including a handsaw, were observed within the room.
2) The oxygen storage room located across the corridor, to the left of the nurse’s station had a key in the door handle and the door was ajar. Inside this room was an oxygen concentrator, a liquid oxygen fill station, a mattress and mattress pads.
3) There were two parallel corridors leading from the resident home areas to the dining room, these corridors each contained doors leading into the staff room. The doors were not equipped with locking mechanisms.

Following the initial tour, the DOC accompanied inspector #622 to view the concerns related to unlocked doors. The DOC said the doors to the maintenance manager’s office and the oxygen storage room should have been locked. She removed the key from the oxygen storage room door handle and locked both doors at the time of viewing. Furthermore, the DOC stated the staff room doors had never been locked.

On a specified date, inspector #103 observed the visitor’s washroom door was unlocked. The door had a key hanging on the wall to the left of the doorway, there was no call bell available in this room.

On a specified date, the Administrator was interviewed by inspector #622. She indicated residents were not to have unsupervised access to the visitor’s washroom, the maintenance manager’s office, the oxygen storage room and the staff room. The Administrator further indicated the doors to these rooms should have been locked. [s. 9. (1) 2.]

Issued on this 2nd day of June, 2017

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

Original report signed by the inspector.