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

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 # / No de registre	Type of Inspection / Genre d'inspection
Dec 21, 2017	2017_363659_0022	022485-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON 000 000

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

THE VILLAGE SENIORS COMMUNITY
101-10TH STREET HANOVER ON N4N 1M9

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

JANETM EVANS (659), DOROTHY GINTHER (568)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): September 27 and 28, 2017, and October 2, 3, 4, 5, 6 and 10, 2017.

The following intakes were completed at the time of the RQI:
Log #005427-17\Critical Incident 2599-000003-17 related to a resident fall with injury.
Log #001857-17\ IL-48998-LO Complaint related to fall prevention and assessment measures.
Log #005500-17\Critical Incident 2599-000010-16 related to a resident fall.

Log #006667-17\IL -50080-LO Complaint related to lack of resident care due to lack of staff.
Log #020409-17\Critical Incident 2599-00014-17 related to alleged neglect of multiple residents.
Log #015254-17\Critical Incident 2599-000009-17 related to a resident fall.
Log #013094-17\IL-51518-LO Complaint related to staffing shortage and 24 hour Registered Nurse.
Log #020874-17\IL-52649-LO Complaint related to staffing shortage and 24 hour Registered Nurse.
Log #021434-17\IL-52775-LO Complaint related to medication administration.
Log #021476-17\Critical Incident related to medication administration.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Regional Director of Operations, the Regional Manager of Education and Resident Services, the Regional Nursing Consultant, the Consultant Pharmacist, the Recreation Manager, the Environmental Services Manager, the Resident Assessment Instrument (RAI) Coordinator back up, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Recreation Aides, Dietary Aides, the Office Manager, the Ward Clerk, Resident Council President, Family Council Representative and residents and family members.

The inspector(s) conducted a tour of the home, and reviewed clinical records and plans of care for relevant residents, pertinent policies and procedures, staffing schedules, and Residents' and Family Council minutes. Observations were made of general maintenance, cleanliness, and condition of the home, infection prevention and control practices, provision of care, staff to resident interactions, medication administration and storage areas and required Ministry of Health and Long-Term Care postings.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Residents' Council
Skin and Wound Care
Sufficient Staffing

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

- **9 WN(s)**
- **5 VPC(s)**
- **3 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. 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 there was at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff on duty and present in the home at all times except as provided for in the regulations.

Review of the registered staff schedules identified the following:
a) The registered nurses worked eight hour shifts.
b) For specified periods between March 2017 to September 2017, there were periods ranging from from 14% of the time to 71% of the time where there was no registered nurse that was an employee of the licensee and a member of the regular nursing staff, on duty and present in the home.

Record review showed on a specified shift that an Agency Registered Nurse (ARN) worked, a medication error was made where an identified resident was administered another resident's medications.

In an interview, a Registered Practical Nurse (RPN) told the Inspector that there was not always a Registered Nurse (RN) on duty in the building. In cases where there was not an RN in the building, the RPN would cover this role.

During an interview the Executive Director (ED) provided documentation which stated that four RNs had resigned and two RNs had been hired since January 2017; as well the ED provided documented evidence of recruitment efforts taken by the home. The ED stated that the home had recently signed a contract with an agency so that they could access temporary RNs. The agency staff would be utilized when they did not have registered practical nurses available to cover for the registered nurse position. The ED acknowledged that despite recruitment efforts the home did not have a registered nurse who was a member of the regular nursing staff on duty and present in the home at all times.

This area of non-compliance was identified during a complaint inspection conducted concurrently during this inspection.

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. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a 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 O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

During an interview Personal Support Workers (PSW) told the Inspector that they would normally have seven staff working the evening shift, one assigned to bathing and the others providing resident care. Currently they were short two staff which left them two staff on each wing to provide care for 35 residents on each wing. When asked how being short staffed impacted the residents; both PSW's said that residents that would normally be toileted may only get a continence product change. They may need to pull the bath shift to assist on the floor and in that case residents would not get their scheduled bath. The PSWs stated they would be late getting all residents to the dining room for their meal, and residents that needed assistance with feeding may have to wait for available staff. Response to call bells and bed/chair alarms would be delayed. In the case of the bed and chair alarms this delay may result in falls not being prevented.

During an interview with the Ward Clerk, they said that the normal staffing levels for Personal Support Workers in the home were as follows:
Days – seven staff from 0600 to 1400 hours, one of which was a bath shift, plus a short shift from 0600 to 1000 hours.
Evenings – seven staff from 1400 hours to 2200 hours, with one staff assigned to bathing.
Nights – prior to June 1, 2017, they had two staff from 2200 to 0600 hours and one staff from 1700 to 0100 hours; after June 1, 2017, they had three staff from 2200 to 0600 hours.

The Ward Clerk shared that when they were short of staff they would start by calling staff on the list to see if they could fill a shift. In the event that they were still short they would offer overtime. The Ward Clerk said that over the last six months they have had periods where it's been difficult to fill shifts as there had been a lot of staff on leave and vacations to cover.

Records provided by the Executive Director (ED) identified that 13 Personal Support Workers had resigned between January and October 2017. During the same time period the home had hired seven Personal Support Workers.

A. Review of the staffing schedules for Personal Support Workers in the home identified the following:

For specified periods between March 2017 to September 2017, there were periods ranging from from 23% of the time to 94% of the time where the home was short of staff.

B. During an interview a PSW shared that since December 2016, they have been chronically short staffed. Quite often they've had to pull the bath shift on both days and evenings in order to have enough staff to provide resident care. The PSW said that currently they were behind five shifts for bathing which would be approximately 50 baths. They further shared that there had been periods where a resident had not received a bath for eight to ten days when they should receive a bath/shower at least twice a week.

A review of seven identified resident's plan of care from Point Click Care (PCC) during specified timeframes, identified that six of the identified residents were to have two baths a week; the other identified resident's plan of care did not provide clear direction related to bathing. Point of Care (POC) documentation for the specified timeframes for the identified residents were reviewed which stated that:

• one identified resident had three out of eight scheduled baths.
• two identified residents had five out of eight scheduled baths.
• two identified residents had six out of eight scheduled baths.
• two identified residents had received four out of eight scheduled baths.

During interviews with three of the identified residents, they told the Inspector that they often went more than a week without a bath.

C. Review of the staff schedule for evenings on a specified date, identified that they were short of staff.

According to the dining schedule on this date, the evening meal was scheduled to start at 1700 hours. Observations of the evening meal were completed. The meals began to be served to residents at 1717 hours by a volunteer; two PSW's assisting with feeding in the dining room and one PSW serving tea and coffee to residents. Two identified residents who required assistance from staff to feed were served their meal approximately 15 minutes before a PSW was available to assist the identified residents to eat.

During an interview PSWs told the Inspector that because they were short staffed this evening it was not possible to provide assistance to all the residents that needed it in a timely manner. They had eight residents that needed assistance with feeding and several others that required some set up help and encouragement. The PSW acknowledged that the identified residents both waited for some time after their meal was served for assistance. By the time they were able to provide the assistance their food was getting cold.

D. Review of the staff schedule for a specified date noted that on day shift the home had two full PSW shifts and two short shifts instead of the usual seven PSW's, one bath shift and one short shift.

During an interview PSWs said that for the last several months the home was chronically short staffed. During the week they usually had five staff on days instead of the normal seven and a short shift. Weekends they were often even shorter. One PSW stated that on the specified date the home only had three staff working on day shift to provide care for 70 residents. When asked how being this short of staff impacted the residents, the PSW said that everything ran late. Limited ADL care was provided to residents and they had to wait for assistance from staff . Response to call bells and bed alarms was

delayed, which meant that for residents that were high risk for falls they had difficulty preventing them. When asked if management or their corporate office had assisted staff when they were short on weekends and evenings, the PSW's said that they had limited management staff over the last few months so that had not happened.

E. i) Review of the staffing schedule on a specified date, on evenings, identified that they had four PSW's instead of seven working.

In an interview a PSW shared that when they were short of staff most of the residents would get their continence product changed but they would not have much time to toilet residents. They were short staffed tonight so an identified resident did not receive the continence care as provided in their plan of care. A second PSW agreed that and said the identified resident would likely be more incontinent as a result.

ii) An identified resident's plan of care from PCC related to toileting stated that the resident required assistance from staff and use of a transfer device to toilet.

In interviews with the identified resident, they shared that staff provided assistance to them for toileting. The identified resident told inspectors that they preferred to get up to the washroom when possible, but when they were short of staff, the staff didn't have time to get them up.

During an interview a PSW said that the identified resident would alert them when they needed to toilet. When asked if the resident's toileting was impacted when they were short of staff, the PSW said that they may not have time to get the resident up to the washroom and in many cases the resident was more incontinent.

F. On a specified date, the Inspector was waiting in the hall of the home looking to speak with a Personal Support Worker (PSW). After more than ten minutes a PSW was observed coming out of a resident's room. The PSW was asked if they might have a moment to speak with the inspector and said that it might be difficult right now as they were overseeing 35 residents while their partner was on break and they were short of staff today. The PSW shared that residents that needed to be toileted would be given a bed pan / urinal until their partner returned because they needed two staff for most residents. If there was an urgent situation they would see if the registered staff was available to assist them. When asked what the direction was from nursing and management in terms of what was to be done when they were short, the PSW said that they were not given any specific direction but told to do their best to complete resident

care. Sometimes they delayed baths depending on how short they were. When asked if management assisted them when they were short, the PSW said "no".

G. A Critical Incident System (CIS) report submitted to the Director on a specified date, was related to incidents that took place during two specified night shifts. The CI description stated that there were entries in the PSW communication book that said care was not completed on seven individual residents.

Review of the investigation notes and interviews with PSWs, who worked night shifts on one or both of the specified dates, showed that on both nights they were short one staff member. This left two staff to provide care for the 70 residents in the home. The PSW's said that because they were short of staff they were not able to reposition and change four residents on their last rounds at approximately 0400 hours. They had documented this in the PSW communication book to ensure that day staff attended to these residents first when they came on shift. The PSWs shared that not completing the last round for all residents was not uncommon when they were short of staff. They did their best to provide care at each of the three rounds on night shift, but being down one person made it difficult on some occasions to complete everything. One PSW stated that they were often behind on night shift because when they came on at 2200 hours there were anywhere from four to thirteen residents still up in their chair that needed their evening care completed before being put to bed. The number of residents needing care depended on how short the evening shift before them had been.

In an interview the Executive Director (ED) told the Inspector that the 2016 staffing plan related to the process to be followed when they were short staffed was vague. When they were advised of a staff absence the Ward Clerk started the process of calling staff. If this failed they offered overtime and staff may work a double shift. If they remained short then they would call registered staff or staff working in other areas of the home that may have cross training as a PSW. The ED stated that they were not aware of management helping out when they were short staffed to this point, aside from the Recreation Manager on occasion. The ED acknowledged that there was no specific direction to staff as to what the focus should be when they were short staffed. The ED said they recognized that the staffing plan was not providing for a staffing mix that was meeting the assessed care and safety needs of residents.

This area of non-compliance was identified during complaint and CIS inspections conducted concurrently during this inspection.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week. O. Reg. 79/10, s. 213 (1).
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week. O. Reg. 79/10, s. 213 (1).
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week. O. Reg. 79/10, s. 213 (1).
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week. O. Reg. 79/10, s. 213 (1).
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Director of Nursing and Personal Care (DONPC) worked regularly in that position on site at the home for the following amount of time per week: In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week.

When inspectors entered the home to commence the Resident Quality Inspection on September 27, 2017, they were told by the Executive Director (ED) that the home had been without a Director of Care (DOC) for the last couple of months. The ED stated that a new DOC was scheduled to start work on October 2, 2017.

On October 2, 2017, Inspectors observed the DOC attend the home for orientation.

During an interview, the Recreation Manager and the Office Manager told the Inspector that they had been without a permanent DOC since the end of March 2017. The Recreation Manager stated that Revera had arranged for one of their corporate staff to act as an interim DOC for the first few months and they were in the home three or four days a week. When they left in late July 2017, the Regional Nursing Consultant became their contact person. They would attend the home one or two days a week and be available for consultation by telephone.

During an interview with the ED, they acknowledged that the home did not have a Director of Nursing and Personal Care (DONPC) that worked regularly in that position on site at the home for at least 35 hours a week during the period of April 2017 and October 2, 2017.

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

In accordance with Ontario Regulation 79/10, s. 48. (1) requires every licensee of a long-term care home to ensure that the following interdisciplinary programs are developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury and 4. A pain management program to identify pain in residents and manage pain.

A review of the home's procedures for post fall management, pain assessments and pain intervention and monitoring documented that pain monitoring was to be initiated with new or worsened pain and that a pain assessment tool would be initiated if the resident said they had pain or showed signs of observed pain.

Review of the clinical record showed an identified resident had multiple falls one specified date. The resident was transferred to hospital following the last fall with an injury.

Record review of the post fall assessment completed showed that following one of the fall incidents the identified resident complained of discomfort with movement; the identified resident was reassessed as having pain when moving.

In interviews, the Registered Nurse (RN) stated the identified resident had complained of pain upon movement of the lower extremity following one of the fall incidents but there was no evidence of an injury. The RN stated if there was no injury, they usually just left a notation note for the physician. The RN acknowledged that a pain assessment had not been completed for the resident's complaint of pain and stated one should have been completed.

In an interview with the Director of Care (DOC), they reviewed the post fall documentation for the identified resident and acknowledged that that a 72 hour pain monitoring sheet had not been completed for the resident and that the expectation was that a 72 hour pain monitoring sheet was completed when a resident demonstrated they had pain. The DOC also stated that the home's policies and procedure had not been followed. [s. 8. (1) (a),s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

During an interview a PSW shared that since December 2016, they have been chronically short staffed. Quite often they've had to pull the bath shift on both days and evenings in order to have enough staff to provide resident care. The PSW said that currently they were behind five shifts for bathing which would be approximately 50 baths. They further shared that there had been periods where a resident had not received a bath for eight to ten days when they should receive a bath/shower at least twice a week.

A review of seven identified resident's plan of care from Point Click Care (PCC) identified that six of the identified residents were to have two baths a week; the other identified resident's plan of care did not provide clear direction related to bathing. Point of Care (POC) documentation for specified periods for the identified residents were reviewed which stated that:

• one identified resident had three out of eight scheduled baths.
• two identified residents had five out of eight scheduled baths.
• two identified residents had six out of eight scheduled baths.
• two identified residents had received four out of eight scheduled baths.

During interviews with three of the identified residents, they told the Inspector that they often went more than a week without a bath.

The licensee has failed to ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. [s. 33. (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 each resident is bathed at a minimum twice weekly by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Review of the clinical record for an identified resident showed specified antipsychotic medication order changes. The clinical record showed the identified resident was ordered a specified antipsychotic medication to be administered once every four weeks; in addition to this there were several scheduled doses of a specified oral antipsychotic medication ordered to be administered for 48 hours.

In an interview the Director of Care (DOC) acknowledged that the administration of the additional doses of specified oral antipsychotic medication and stated this was a medication error.

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. This area of non-compliance was identified during a complaint inspection conducted concurrently during this inspection. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Review of the clinical record for the identified resident showed specified antipsychotic medication order changes. The clinical record showed the identified resident was ordered several scheduled doses of a specified antipsychotic medication and was administered additional doses of the specified antipsychotic medication.

A medication incident report for the identified resident documented the identified resident was administered an incorrect dose of the "as needed" antipsychotic medication on a specified date . The medication incident report documented the resident was assessed and the physician was notified. The next shift was advised to monitor the resident.

The home's LTC Psychotropic Medication procedure documented "The interdisciplinary team, in collaboration with the Physician/NP, will have a formalized and regularly scheduled psychotropic medication monitoring, review and documentation process in place for assessment of the ongoing need for medications".

Review of a hard copy of the resident's chart showed a Psychotropic Medication Monitoring Record which was labelled with the resident's name and the specified antipsychotic medication and dose were identified. The form was otherwise incomplete.

In an interview with a Registered Practical Nurse (RPN), they stated that when there were changes to a dose or there were new orders for psychotropic medication there was a monitoring tool that staff were to use document if a resident was confused, agitated or if the behaviour was being managed by the drugs.

In an interview with the Director of Care (DOC), they acknowledged that that there was no documented evidence of monitoring the resident for psychotropic medication use and that there was an expectation for monitoring residents who were administered psychotropic medication.

The licensee has failed to ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

This area of non-compliance was identified during a complaint inspection conducted concurrently during this inspection. [s. 134. (a)]

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 when any resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending

physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A medication incident summary provided by the home for second quarter 2017, showed there were eight medication incidents received to the pharmacy medication incident reporting (MIRS) and for quarter three, there were two medication incidents reported to the MIRS.

A review of the medication incidents for two identified residents was completed; as well as a review of the identified resident's clinical record. In addition to this, a Complaint and Critical Incident System report were reviewed related to a medication incident where an identified resident had been administered another residents' medication and had an adverse reaction following this incident. There was no medication incident report provided from the MIRS for third identified resident, and documentation of the medication incident was reviewed in the progress notes of the resident's clinical record.

A review of the medication incidents was completed with the Registered Nurse (RN) in charge, who acknowledged that there was no MIRS completed for the medication incident related to the third identified resident and that the pharmacist would not have been notified of the medication incident/adverse drug reaction.

The RN in charge stated that the Medical Director would be notified of medication incidents during the Professional Advisory Committee (PAC) meeting. The RN in charge acknowledged from review of the March 2017 and June 2017 PAC meeting minutes there was no documentation related to medication incidents that were shared with the Medical Director.

In an interview, the Consultant Pharmacist stated that they were only aware of medication incidents if a report was entered electronically in MIRS. In addition to this they said that they had not attended a PAC meeting at the home in the last six months and had not provided the home with documentation related to medication incidents.

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending

physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. [s. 135. (1)]

2. The licensee has failed to ensure that
(a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed;
(b) corrective action was taken as necessary; and
(c) a written record was kept of everything required under clauses (a) and (b).

A review of three medication incidents was completed. Two paper medication incident reports (MIRS) from the home's electronic documentation system for two identified residents and a third identified resident from a Complaint and Critical Incident System report. The inspector also reviewed clinical records and Risk Management in PCC for the period from June – Sept 2017 for the identified residents.

For one identified resident, there was no medication incident report completed via the home's MIRS documentation . An entry in the resident's progress notes documented the medication incident for this identified resident. The progress note entry stated that the identified resident was administered another resident's medications. The resident was initially assessed and treated at the home; the resident was later transferred to hospital for assessment. There was no documented evidence of any review or analysis related to this incident.

Review of the home's policy related to medication incidents documented that a medication incident report would be initiated by the individual discovering the medication incident and the Director of Care (DOC) would maintain a copy for trend analysis. Medication incidents will be summarized, discussed and actions developed as necessary.

In an interview with the Registered Nurse (RN) in charge, they stated that the review and analysis of medication incidents and adverse drug reactions should be done by the Director of Care or Assistant Director of Care. In their absence the RN was uncertain who was responsible for this task or if any one had completed this. The RN in charge stated that there was no documented evidence to provide inspector related to the review, analysis or corrective action taken for these reviewed medication incidents.

The licensee has failed to ensure that
(a) all medication incidents and adverse drug reactions were documented, reviewed and

analyzed;
(b) corrective action was taken as necessary; and
(c) a written record was kept of everything required under clauses (a) and (b). [s. 135. (2)]

3. The licensee had failed to ensure that:
(a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions;
(b) any changes and improvements identified in the review were implemented; and
(c) a written record was kept of everything provided for in clause (a) and (b).

A review of a Medication Incident Reporting summary document showed medication incidents from February 7, 2017 to August 29, 2017.

From review of medication incidents with the Registered Nurse (RN) in charge, they stated that the medication incident for an identified resident , had been completed in the progress notes; there was no medication incident report (MIRS) completed. The RN in charge stated that the quarterly analysis of the medication incidents and adverse drug reactions would have been completed at the Professional Advisory Committee (PAC) meeting and would be documented in the minutes. The RN in charge reviewed the PAC minutes for March and June 2017 and acknowledged there was no documentation related to medication incidents being reviewed in June 2017; for March 2017 there was a notation related to medication errors but there were no details documented about the errors and no changes/improvements were identified.

In an interview with Consultant Pharmacist, they stated they completed a review of medication incidents/adverse drug reactions and analyzed this for trends. The pharmacist stated they only had knowledge of the medication incidents that were documented in their electronic MIRS. The pharmacist stated normally they would present the information at the Professional Advisory Committee (PAC) meeting but they had not been invited to attend the PAC meeting and they had not provided the home with this information in approximately the last 6 months. The pharmacist had no knowledge related to corrective actions taken or of the home's implementation of any improvements in response to medication incidents or adverse drug reactions.

The licensee failed to ensure that:
(a) a quarterly review was undertaken of all medication incidents and adverse drug

reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions;
(b) any changes and improvements identified in the review were implemented; and
(c) a written record was kept of everything provided for in clause (a) and (b). [s. 135. (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 every medication incident involving a resident and every adverse drug reaction is: documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

The licensee will also ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed; corrective action is taken as necessary, and a written record is kept of everything.

In addition to this the licensee will ensure a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; any changes and improvements identified in the review are implemented, and
a written record is kept of everything provided for in clause, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following analysis and follow-up action including:
i. the immediate actions that had been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence

A Critical Incident System Report (CIS) was submitted to the Director on a specified date. The description of the incident stated that entries had been made in the PSW communication book that for specified dates on night shift, that care was not completed for seven individual residents. The analysis and follow-up section of the CIS report stated that the long term actions planned to correct the situation and prevent recurrence depended on the outcome of the investigation.

During an interview with the Executive Director (ED), they said that they were aware of the incident described in CIS report but they were not working in the home at the time and were not involved in the initial investigation. The ED acknowledged that several changes were made to their communication system to prevent recurrence of this situation and that the CIS had not been amended to reflect the long term actions and outcome of the investigation. [s. 104. (1) 4.]

Issued on this 18th day of January, 2018

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

Original report signed by the inspector.

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

Ministére 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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JANETM EVANS (659), DOROTHY GINTHER (568)
Inspection No. / No de l'inspection :	2017_363659_0022
Log No. / No de registre :	022485-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 21, 2017
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, 000-000
LTC Home / Foyer de SLD :	THE VILLAGE SENIORS COMMUNITY 101-10TH STREET, HANOVER, ON, N4N-1M9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Dylan Subject

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

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 will 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 / Motifs :

1. The licensee has failed to ensure that there was at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff on duty and present in the home at all times except as provided for in the regulations.

Review of the registered staff schedules identified the following:
a) The registered nurses worked eight hour shifts.
b) For specified periods between March 2017 to September 2017, there were periods ranging from from 14% of the time to 71% of the time where there was no registered nurse that was an employee of the licensee and a member of the regular nursing staff, on duty and present in the home.

Record review showed on a specified shift that an Agency Registered Nurse (ARN) worked, a medication error was made where an identified resident was administered another resident's medications.

In an interview, a Registered Practical Nurse (RPN) told the Inspector that there was not always a Registered Nurse (RN) on duty in the building. In cases where there was not an RN in the building, the RPN would cover this role.

During an interview the Executive Director (ED) provided documentation which stated that four RNs had resigned and two RNs had been hired since January 2017; as well the ED provided documented evidence of recruitment efforts taken by the home. The ED stated that the home had recently signed a contract with an agency so that they could access temporary RNs. The agency staff would be utilized when they did not have registered practical nurses available to cover for the registered nurse position. The ED acknowledged that despite recruitment efforts the home did not have a registered nurse who was a member of the regular nursing staff on duty and present in the home at all times.

This area of non-compliance was identified during a complaint inspection conducted concurrently during this inspection.

The severity of the issue was determined to be potential for harm and the scope of the issue was a pattern. The home had a history of related noncompliance during the Resident Quality Inspection #2016_325568_0027, November 22, 2016. (568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a 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
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Order / Ordre :

The licensee will ensure their staffing plan provides for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and Regulation. In addition, the plan will promote continuity of care by minimizing the number of different staff who provide nursing and personal support services to each resident; and include a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work.

Additionally, the home will ensure that the staffing mix provides for the care needs of the residents including:
a) Identified residents and all residents receive two baths a week per the residents' assessed care needs;
b) Identified residents and all residents receive the appropriate assistance with feeding per the residents' assessed care needs; and
c) Identified residents and all residents receive the appropriate assistance with toileting as per the resident's assessed care need.

Grounds / Motifs :

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

During an interview Personal Support Workers (PSW) told the Inspector that they would normally have seven staff working the evening shift, one assigned to bathing and the others providing resident care. Currently they were short two staff which left them two staff on each wing to provide care for 35 residents on each wing. When asked how being short staffed impacted the residents; both PSW's said that residents that would normally be toileted may only get a continence product change. They may need to pull the bath shift to assist on the floor and in that case residents would not get their scheduled bath. The PSWs stated they would be late getting all residents to the dining room for their meal, and residents that needed assistance with feeding may have to wait for available staff. Response to call bells and bed/chair alarms would be delayed. In the case of the bed and chair alarms this delay may result in falls not being prevented.

During an interview with the Ward Clerk, they said that the normal staffing levels for Personal Support Workers in the home were as follows:
Days – seven staff from 0600 to 1400 hours, one of which was a bath shift, plus a short shift from 0600 to 1000 hours.
Evenings – seven staff from 1400 hours to 2200 hours, with one staff assigned to bathing.
Nights – prior to June 1, 2017, they had two staff from 2200 to 0600 hours and one staff from 1700 to 0100 hours; after June 1, 2017, they had three staff from 2200 to 0600 hours.

The Ward Clerk shared that when they were short of staff they would start by calling staff on the list to see if they could fill a shift. In the event that they were still short they would offer overtime. The Ward Clerk said that over the last six months they have had periods where it's been difficult to fill shifts as there had been a lot of staff on leave and vacations to cover.

Records provided by the Executive Director (ED) identified that 13 Personal Support Workers had resigned between January and October 2017. During the same time period the home had hired seven Personal Support Workers.

A. Review of the staffing schedules for Personal Support Workers in the home identified the following:

For specified periods between March 2017 to September 2017, there were periods ranging from from 23% of the time to 94% of the time where the home was short of staff.

B. During an interview a PSW shared that since December 2016, they have been chronically short staffed. Quite often they've had to pull the bath shift on both days and evenings in order to have enough staff to provide resident care. The PSW said that currently they were behind five shifts for bathing which would be approximately 50 baths. They further shared that there had been periods where a resident had not received a bath for eight to ten days when they should receive a bath/shower at least twice a week.

A review of seven identified resident's plan of care from Point Click Care (PCC) during specified timeframes, identified that six of the identified residents were to have two baths a week; the other identified resident's plan of care did not provide clear direction related to bathing. Point of Care (POC) documentation for the specified timeframes for the identified residents were reviewed which stated that:
• one identified resident had three out of eight scheduled baths.
• two identified residents had five out of eight scheduled baths.
• two identified residents had six out of eight scheduled baths.
• two identified residents had received four out of eight scheduled baths.

During interviews with three of the identified residents, they told the Inspector that they often went more than a week without a bath.

C. Review of the staff schedule for evenings on a specified date, identified that they were short of staff.

According to the dining schedule on this date, the evening meal was scheduled to start at 1700 hours. Observations of the evening meal were completed. The meals began to be served to residents at 1717 hours by a volunteer; two PSW's assisting with feeding in the dining room and one PSW serving tea and coffee to residents. Two identified residents who required assistance from staff to feed were served their meal approximately 15 minutes before a PSW was available to assist the identified residents to eat.

During an interview PSWs told the Inspector that because they were short staffed this evening it was not possible to provide assistance to all the residents that needed it in a timely manner. They had eight residents that needed assistance with feeding and several others that required some set up help and encouragement. The PSW acknowledged that the identified residents both waited for some time after their meal was served for assistance. By the time they were able to provide the assistance their food was getting cold.

D. Review of the staff schedule for a specified date noted that on day shift the home had two full PSW shifts and two short shifts instead of the usual seven PSW's, one bath shift and one short shift.

During an interview PSWs said that for the last several months the home was chronically short staffed. During the week they usually had five staff on days instead of the normal seven and a short shift. Weekends they were often even shorter. One PSW stated that on the specified date the home only had three staff working on day shift to provide care for 70 residents. When asked how being this short of staff impacted the residents, the PSW said that everything ran late. Limited ADL care was provided to residents and they had to wait for assistance from staff . Response to call bells and bed alarms was delayed, which meant that for residents that were high risk for falls they had difficulty preventing them. When asked if management or their corporate office had assisted staff when they were short on weekends and evenings, the PSW's said that they had limited management staff over the last few months so that had not happened.

E. i) Review of the staffing schedule on a specified date, on evenings, identified that they had four PSW's instead of seven working.

In an interview a PSW shared that when they were short of staff most of the residents would get their continence product changed but they would not have much time to toilet residents. They were short staffed tonight so an identified resident did not receive the continence care as provided in their plan of care. A second PSW agreed that and said the identified resident would likely be more incontinent as a result.

ii) An identified resident's plan of care from PCC related to toileting stated that the resident required assistance from staff and use of a transfer device to toilet.

In interviews with the identified resident, they shared that staff provided assistance to them for toileting. The identified resident told inspectors that they preferred to get up to the washroom when possible, but when they were short of staff, the staff didn't have time to get them up.

During an interview a PSW said that the identified resident would alert them when they needed to toilet. When asked if the resident's toileting was impacted when they were short of staff, the PSW said that they may not have time to get the resident up to the washroom and in many cases the resident was more incontinent.

F. On a specified date, the Inspector was waiting in the hall of the home looking to speak with a Personal Support Worker (PSW). After more than ten minutes a PSW was observed coming out of a resident's room. The PSW was asked if they might have a moment to speak with the inspector and said that it might be difficult right now as they were overseeing 35 residents while their partner was on break and they were short of staff today. The PSW shared that residents that needed to be toileted would be given a bed pan / urinal until their partner returned because they needed two staff for most residents. If there was an urgent situation they would see if the registered staff was available to assist them. When asked what the direction was from nursing and management in terms of what was to be done when they were short, the PSW said that they were not given any specific direction but told to do their best to complete resident care. Sometimes they delayed baths depending on how short they were. When asked if management assisted them when they were short, the PSW said "no".

G. A Critical Incident System (CIS) report submitted to the Director on a specified date, was related to incidents that took place during two specified night shifts. The CI description stated that there were entries in the PSW communication book that said care was not completed on seven individual residents.

Review of the investigation notes and interviews with PSWs, who worked night shifts on one or both of the specified dates, showed that on both nights they were short one staff member. This left two staff to provide care for the 70 residents in the home. The PSW's said that because they were short of staff they were not able to reposition and change four residents on their last rounds at

approximately 0400 hours. They had documented this in the PSW communication book to ensure that day staff attended to these residents first when they came on shift. The PSWs shared that not completing the last round for all residents was not uncommon when they were short of staff. They did their best to provide care at each of the three rounds on night shift, but being down one person made it difficult on some occasions to complete everything. One PSW stated that they were often behind on night shift because when they came on at 2200 hours there were anywhere from four to thirteen residents still up in their chair that needed their evening care completed before being put to bed. The number of residents needing care depended on how short the evening shift before them had been.

In an interview the Executive Director (ED) told the Inspector that the 2016 staffing plan related to the process to be followed when they were short staffed was vague. When they were advised of a staff absence the Ward Clerk started the process of calling staff. If this failed they offered overtime and staff may work a double shift. If they remained short then they would call registered staff or staff working in other areas of the home that may have cross training as a PSW. The ED stated that they were not aware of management helping out when they were short staffed to this point, aside from the Recreation Manager on occasion. The ED acknowledged that there was no specific direction to staff as to what the focus should be when they were short staffed. The ED said they recognized that the staffing plan was not providing for a staffing mix that was meeting the assessed care and safety needs of residents.

This area of non-compliance was identified during complaint and CIS inspections conducted concurrently during this inspection.

The severity of the issue was determined to be potential for harm and the scope of the issue was a widespread. The home had a history of unrelated noncompliance.

(568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2018

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week.
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week.
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week.
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week.
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Order / Ordre :

The licensee will ensure that the home's Director of Nursing and Personal Care (DONPC) works regularly in that position on site at the home for the following amount of time per week: In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's Director of Nursing and Personal Care (DONPC) worked regularly in that position on site at the home for the following amount of time per week: In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week.

When inspectors entered the home to commence the Resident Quality Inspection on September 27, 2017, they were told by the Executive Director (ED) that the home had been without a Director of Care (DOC) for the last couple of months. The ED stated that a new DOC was scheduled to start work on October 2, 2017.

On October 2, 2017, Inspectors observed the DOC attend the home for orientation.

During an interview, the Recreation Manager and the Office Manager told the Inspector that they had been without a permanent DOC since the end of March 2017. The Recreation Manager stated that Revera had arranged for one of their corporate staff to act as an interim DOC for the first few months and they were in the home three or four days a week. When they left in late July 2017, the Regional Nursing Consultant became their contact person. They would attend the home one or two days a week and be available for consultation by telephone.

During an interview with the ED, they acknowledged that the home did not have a Director of Nursing and Personal Care (DONPC) that worked regularly in that position on site at the home for at least 35 hours a week during the period of April 2017 and October 2, 2017.

The severity of the issue was determined to be potential for harm and the scope of the issue was a pattern. The home had a history of unrelated noncompliance.

(568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 19, 2018

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

Ministére 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

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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 21st day of December, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

Ministére 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

Name of Inspector / Nom de l'inspecteur : JanetM Evans

Service Area Office / Bureau régional de services : London Service Area Office