Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 22, 2020	2020_796754_0038	023832-20	Critical Incident System

Licensee/Titulaire de permis

peopleCare Not-For-Profit Homes Inc.
735 Bridge Street West Waterloo ON N2V 2H1

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

peopleCare A.R. Goudie Kitchener
369 Frederick Street Kitchener ON N2H 2P1

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

TAWNIE URBANSKI (754)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 7-8, 2020.

The following intake was completed during this critical incident inspection:
Log #023832, related to an unexpected resident death.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Maintenance Service Staff, and SouthWest Door Automatics staff.

Observations related to resident bathroom doors at the home and staff to resident interactions was completed. A review of the identified resident's clinical records and other relevant documentation including bathroom door audits was completed.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the resident bathroom doors were maintained in a safe condition and in a good state of repair.

A) A resident's bathroom door was not in a good state of repair and injured a resident. The Registered Nurse (RN) was called to assess the resident after their bathroom door had fallen on them. The resident was in pain and additional assessments were required for the resident.

The assessment results indicated that the resident had a significant injury related to the incident. The resident died several days later, as a result of complications related to their injuries.

There were previous incidents reported, where bathroom doors in the home had come off the sliding track and they were repaired. There was no preventative maintenance program in place to address bathroom doors at the home.

B) The home's internal bathroom door audit showed that another resident room was missing the roller at the top of their bathroom door.

The inspector observed the bathroom door missing the roller and noted that it was still missing the wheel that would have been within the track at the top of the door. The inspector noted that there was only a small peg at the top holding the door within the sliding track. The resident was in their room at this time.

The Maintenance service provider was aware that the bathroom door was not in a good state of repair, but had not fixed the door 8 days later.

Not ensuring the home’s bathroom doors were maintained in a safe condition and good state of repair caused a resident serious injury and death. Not immediately fixing all bathroom doors in need of repair or maintenance put other residents at risk of injury.

Sources: Critical Incident Report, resident progress notes, the home's door audit, interviews with Maintenance Staff, RN, PSW, and other staff, and inspector’s observations. [s. 15. (2) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 6th day of January, 2021

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	TAWNIE URBANSKI (754)
Inspection No. / No de l’inspection :	2020_796754_0038
Log No. / No de registre :	023832-20
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 22, 2020
Licensee / Titulaire de permis :	peopleCare Not-For-Profit Homes Inc. 735 Bridge Street West, Waterloo, ON, N2V-2H1
LTC Home / Foyer de SLD :	peopleCare A.R. Goudie Kitchener 369 Frederick Street, Kitchener, ON, N2H-2P1
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Florin Perte

To peopleCare Not-For-Profit Homes Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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 # / No d'ordre : 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. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The licensee must be compliant with s. 15. (2) (c) of the LTCHA.

Specifically, the licensee must ensure that:

A) The bathroom doors in resident rooms are kept in safe condition and in a good state of repair.

B) Quarterly audits of all resident bathroom doors are completed, deficiencies documented, and repairs or maintenance completed in a timely manner to ensure the doors are maintained in a safe condition, rust-free (including the bottom pivots), and a good state of repair. When the home cannot repair the doors immediately, steps are taken to ensure resident's do not have access to doors needing repair or maintenance.

C) A written record of the bathroom door audits, findings, and repairs or maintenance is kept within the home.

D) Ensure that all disrepair for bathroom doors is reported to the Maintenance Service Provider immediately through the ticket system used within the home, using the priority choice of emergency.

Grounds / Motifs :

1. 1. The licensee failed to ensure the bathroom doors were maintained in a safe

condition and in a good state of repair.

A) A resident's bathroom door came off the sliding track at the top of the door, and injured a resident. The Registered Nurse (RN) was called to assess the resident after their bathroom door had fallen on them. The resident was in pain and additional assessments were required for the resident.

The assessment results indicated that the resident had a significant injury related to the incident. The resident died several days later, as a result of complications related to their injuries.

There were previous incidents reported, where bathroom doors in the home had come off the sliding track and they were repaired. There was no preventative maintenance program in place to address bathroom doors at the home.

B) The home's internal bathroom door audit showed that another resident room was missing the roller at the top of their bathroom door.

The inspector observed the bathroom door missing the roller and noted that it was still missing the wheel that would have been within the track at the top of the door. The inspector noted that there was only a small peg at the top holding the door within the sliding track. The resident was in their room at this time.

The Maintenance service provider was aware that the bathroom door was not in a good state of repair, but had not fixed the door 8 days later.

Not ensuring the home's bathroom doors were maintained in a safe condition and good state of repair caused a resident serious injury and death. Not immediately fixing all bathroom doors in need of repair or maintenance put other residents at risk of injury.

Sources: Critical Incident Report, resident progress notes, the home's door audit, interviews with Maintenance Staff, RN, PSW, and other staff, and inspector's observations.

An order was made by taking the following factors into account:

Severity: The licensee not ensuring that all resident bathroom doors were maintained in a safe condition and good state of repair posed actual serious harm to a resident who sustained injuries which resulted in the resident's death.

Scope: This non-compliance was isolated as two of the seven resident bathroom doors inspected were not maintained in a safe condition or good state of repair.

Compliance History: One voluntary plan of correction (VPC) was issued to the home related to a different section of the legislation in the past 36 months. (754)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Mar 15, 2021

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 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 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 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 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 22nd day of December, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Tawnie Urbanski

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