Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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347 Preston St, 4th Floor
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 1, 2, 8, 14, 15, 21, 2011	2011_028102_0023	Critical Incident

Licensee/Titulaire de permis

CHARTWELL MASTER CARE LP
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

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

BALLYCLIFFE LODGE NURSING HOME
70 STATION STREET, AJAX, ON, L1S-1R9

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

WENDY BERRY (102)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, several registered and non registered nursing staff, several residents.

During the course of the inspection, the inspector(s) conducted two critical incident inspections; toured the 1st, 2nd and 3rd floors of resident care; checked door security on some resident accessible doors; reviewed health care records for 1 resident; observed the condition of some of the equipment and furnishings provided for residents; reviewed Resident and Family Council meeting minutes for September 2011, "Partnership Communication Binders", and staff education record for 2010 and 2011.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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).

Findings/Faits saillants :

1. Free standing clothes closets are provided in residents' bedrooms. Some of the closets have non intact surfaces that are broken and crumbling and/or have pieces missing. 18 of 39 closets that were checked were identified as being unsteady and at potential risk of tipping over.
- One or more unsteady closets were identified in 13 specified rooms.
- Closet door centre support sections were broken or missing from one closet in each of 2 specified rooms.
- One closet in an identified room had a loose section with nails protruding along the length of the front right corner.
Note: closets in all rooms were not checked.
On November 02, 2011, actions were observed being taken to stabilize closets in residents' rooms.

2. Critical incident report # 2658-000012-11 identifies that in October, 2011, a resident leaned on the foot board of a bed. The foot board fell off causing the resident to fall to the floor and sustain an injury.
- In residents' bedrooms, foot boards are secured to bed frames by 4 screws and/or bolts.
- On November 01, 2011 the foot boards of 4 beds were observed to have one or more screws or bolts missing in the following rooms: room XXX (2 beds); room YYY (2 beds)
Note: the missing screws/bolts were all observed to be in place on November 02, 2011.

3. On September 01, 2011 the wheelchair provided for an identified resident was identified on critical incident report #2658-000011-11, as missing a "protective knob" on the wheelchair's foot rest release which was identified as causing a skin laceration to the resident's lower leg.

4. On November 02, 2011, the wheelchair provided for the use of the same identified resident was observed to be missing a protective cover over an accessible sharp edged fitting that attaches the front right wheel mount to the wheelchair's frame.
-The resident is identified a specific "Care Plan", date initiated June 2011, as having frail skin.
-"Progress Notes" entry dated October 2011 identifies that the resident sustained a lower leg injury on the leg attachment for the wheelchair.

Furnishings and equipment are not maintained in a safe condition and a good state of repair. [s. 15.(2)(c)]

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. 9. Doors in a home

Specifically failed to comply with the following subsections:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents.
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans. O. Reg. 79/10, s. 9. (1).

Findings/Faits saillants :

1. 3 resident accessible doors leading to stairways have door alarms that are not connected to an audio visual enunciator panel at the closest nursing station:
-2 doors lead from the 2nd floor corridor and 1 door leads from the 3rd floor corridor
-the identified doors are equipped with door alarms that are connected to a 1st floor nursing station audio visual enunciator panel.
-the 2nd and 3rd floor share a nursing station on the 2nd floor

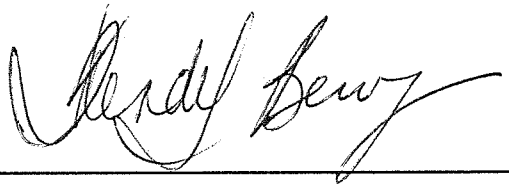
[s.9.(1)1.iii.B]

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 all stairway doors that are accessible to residents are equipped with an audible door alarm system that is connected to an audio visual enunciator panel at the closest nursing station to the door., to be implemented voluntarily.

Issued on this 24th day of November, 2011

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



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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	WENDY BERRY (102)
Inspection No. / No de l'inspection :	2011_028102_0023
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Nov 1, 2, 8, 14, 15, 21, 2011
Licensee / Titulaire de permis :	CHARTWELL MASTER CARE LP 100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1
LTC Home / Foyer de SLD :	BALLYCLIFFE LODGE NURSING HOME 70 STATION STREET, AJAX, ON, L1S-1R9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	DUNA QAQISH

To CHARTWELL MASTER CARE LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

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

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. 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 home, furnishings and equipment are to be maintained in safe condition and in a good state of repair which includes:
1. head boards and foot boards on all residents' beds are to be kept tightly secured to the bed frames at all times;
2. wheelchairs used by residents will have all necessary protective coverings provided and maintained as per manufacturers' specifications and as required to meet the safety needs of individual residents, including those at risk of skin tears;
3. free standing clothes closets with damaged and non intact surfaces are to be repaired or replaced as necessary;
4. all resident accessible free standing closets are to be equipped, repaired or replaced as necessary to prevent accidental tipping.

Grounds / Motifs :

1. Free standing clothes closets are provided in residents' bedrooms. Some of the closets have non intact surfaces that are broken and crumbling and/or have pieces missing. 18 of 39 closets that were checked were identified as being unsteady and at potential risk of tipping over.
- One or more unsteady closets were identified in 13 specified rooms.
- Closet door centre support sections were broken or missing from one closet in each of two identified rooms.
- One closet in one room had a loose section with nails protruding along the length of the front right corner.
Note: closets in all rooms were not checked.
On November 02, 2011, actions were observed being taken to stabilize closets in residents' rooms.

2. Critical incident report # 2658-000012-11 identifies that in October, 2011, a resident leaned on the foot board of a bed. The foot board fell off causing the resident to fall to the floor and sustain an injury.
- In residents' bedrooms, foot boards are secured to bed frames by 4 screws and/or bolts.
- On November 01, 2011 the foot boards of 4 beds were observed to have one or more screws or bolts missing in the following rooms: room XXX (2 beds); room YYY (2 beds)
Note: the missing screws/bolts were all observed to be in place on November 02, 2011.

3. In September, 2011 the wheelchair provided for a resident was identified on critical incident report #2658-000011-11, as missing a "protective knob" on the wheelchair's foot rest release which was identified as causing a skin laceration to the resident's lower leg.

4. On November 02, 2011, the wheelchair provided for the use of the same identified resident was observed to be missing a protective cover over an accessible sharp edged fitting that attaches the front right wheel mount to the wheelchair's frame.
-The resident is identified in the "Care Plan", date initiated June 2011, as having frail skin.
-"Progress Notes" entry dated October 2011 identifies that the resident sustained a lower leg injury on the leg attachment for the wheelchair.

Furnishings and equipment are not maintained in a safe condition and a good state of repair. [s. 15.(2)(c)] (102)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2012

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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 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

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

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 21st day of November, 2011

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : WENDY BERRY

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