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

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 13, 30, 2014	2014_195166_0014	O-000380-14	Resident Quality Inspection

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

CAROLINE TOMPKINS (166), MARIA FRANCIS-ALLEN (552), PATRICIA BELL (571)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 6, 7, 8, 9, 12, 13, 14, 2014.

Complaint Log O-001041-13 was inspected concurrently with the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with Residents, the Vice-President of the Residents' Council, Family, the Administrator, the Director of Care, the Corporate Nursing Consultant, the Food Service Supervisor, the Program Manager, the Social Worker, Registered Nurses, Registered Practical Nurses, Environmental personnel, Personal Support Workers

During the course of the inspection, the inspector(s) observed staff to resident interactions, observed a meal service, observed medication administration to residents, reviewed the Resident and Family Council meeting minutes, residents' clinical records and reviewed the licensee's policies related to bed rails, restraints, personal assistance service devices, restraint monitoring records, pharmacy and therapeutics, resident abuse and whistleblowing, weights and heights of residents, resident care plans, infection control program, staff and resident immunization program and social and recreational programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that a door leading to an outside area is equipped with locks to restrict unsupervised access to the area by residents.
On May 6, 2014, during the initial tour of the home, Inspector #571 observed that the door in the physio room opened to the outside. The door did not have a locking mechanism in place and could allow residents to exit into a large outdoor area that is unsupervised.
The Administrator was notified on May 6, 2014 and a temporary locking mechanism was put into use on the door leading into the physio room.
Interview with the Administrator and the Director Care indicated that residents have not used that door to exit to the outside. [s. 9. (1) 1.1.]

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 LTCHA, 2007 S.O. 2007, c.8, s. 10. Recreational and social activities

Specifically failed to comply with the following:

s. 10. (2) Without restricting the generality of subsection (1), the program shall include services for residents with cognitive impairments, and residents who are unable to leave their rooms. 2007, c. 8, s. 10 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the recreational and social activities program includes services for residents with cognitive impairments and residents who are unable to leave their room.
Review of 3 months documentation related to resident participation in activities (ActivityPro) which included physical, intellectual, emotional, social and spiritual programs and interview with the Program Manager, indicated that 17 identified residents with cognitive impairments and/or those residents who are unable to leave their rooms had zero program contacts confirmed by zero program minutes documented within the three months reviewed.
Zero program contact was observed by Inspector #166 for the period from May 6, 2014 to May 9, 2014 and from May 12, 2014 to May 14, 2014 for cognitively impaired residents #05,#5833,#5815.
Zero program contacts was observed by Inspector #166 for the period from May 6, 2014 to May 9, 2014 and from May 12, 2014 to May 14, 2014 for Resident #07, who is not able to leave their room without assistance. [s. 10. (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 the licensee shall ensure that there is an organized program of recreation and social programs that meets the needs and the interests of residents with cognitive impairments and those residents who are unable to leave their rooms, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.
There is no documented evidence that the licensee responds in writing to the concerns or recommendations brought forward by the Residents' Council.
Interview with the Administrator indicated that concerns or recommendations from the Residents' Council are directed to the managers of the departments related to area of concern and the managers of those departments respond verbally to the Resident's Council. [s. 57. (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 the licensee shall ensure within 10 days of receiving concerns or recommendations from the Residents' Council, respond to the Residents' Council in writing, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee failed to ensure that where a drug that is to be destroyed is not a controlled substance, it will be done by a team acting together and composed of:
i. one member of the registered nursing staff appointed by the Director of Nursing and Personal Care,and
ii. one other staff member appointed by the Director of Nursing.
Interview with Registered Practical Nurse #102 ,the Director of Care and the Corporate Consultant indicates that the non controlled medications are not destroyed by a staff team prior to being removed from the home by a contracted company . [s. 136. (3) (b)]

2. The licensee failed to ensure that when a drug is destroyed, the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable.
Interview with Registered Practical Nurse #102, the Director of Care and the Corporate Consultant indicated that the non controlled medications are not altered or denatured to such an extent that its consumption is rendered impossible or improbable prior to being removed from the home by a contracted company.
On May 9, 2014, Inspector #166, observed an open container in the medication room that was full of discontinued non controlled medications which had not been altered or denatured. [s. 136. (6)]

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 the license shall ensure that where a drug that is to be destroyed that is not a controlled substance, it will be done by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing,and one other staff member appointed by the Director of Nursing and when a drug is destroyed, the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
2. Residents must be offered immunization against influenza at the appropriate time each year. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident admitted to the home is screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee
Review of clinical records for Residents #5815 and 5795 indicated:
Resident #5815 was admitted to the home February 23, 2012. The TB screening for Resident #5815 was completed March 22,2012.
Resident #5795 was admitted to the home March 22/2011. The TB screening for Resident #5795 was completed on April 13, 2011. [s. 229. (10) 1.]

2. The licensee failed to ensure that residents are offered immunization against influenza at the appropriate time each year
Review of immunization records for Resident #5795 indicated, the resident was admitted to the home in April 2011 and received Influenza immunization in 2011 and in 2012. Resident #5795 did not receive influenza immunization in 2013.
Interview with the Director of Care and review of clinical documentation could find no evidence to indicate that the resident and/or family had refused to receive immunization against influenza in 2013 [s. 229. (10) 2.]

3. The Licensee failed to ensure that staff are screened for tuberculosis in accordance with evidence-based practices and if there are none, in accordance with prevailing practices.
Interview with the Administrator and the record review of three staff members indicated
that these staff members have not been screened for tuberculosis in accordance with evidenced based practice, if there are none, in accordance with prevailing practices.
Interview with the Administrator indicated staff are not screened for tuberculosis. [s. 229. (10) 4.]

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 the licensee shall ensure that each resident admitted to the home is screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee and each resident admitted to the home is offered immunization against influenza, pnuemoccocus, tetanus and diphtheria., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to fully respect and promote the resident's right to have his or her personal health information (within the Personal Health Information Protection Act, 2004) kept confidential.
During observation of the medication pass it was observed that the medication packages which identified names of residents and the medication the residents were administered were thrown in the garbage, potentially risking the residents' privacy related to personal health information.
Interview with the Registered Practical Nurse, who was administering the medications indicated, it was the normal practice to discard the medication packages into the regular garbage. [s. 3. (1) 11. iv.]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home is a safe and secure environment for the residents.
On May 13/14, Inspector #552 witnessed Resident #6 attempting to go up the stairs and under the barricade between the 2nd and the 3rd floor of the home. The wheels of the resident's walker were on the first stair and the back of the resident's neck was caught under the barricade.
The Inspectors released the barricade and called for assistance. Staff assisted the resident from the area and assessed the resident for injuries. There were no injuries to the resident noted at the time. [s. 5.]

WN #8: 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 Long Term Care Home Act S.O. 2007, s.21 states that the licensee shall ensure that there are written procedures that comply with the regulations for initiating complaints and how the licensee deals with complaints. Regulation 10/79 s. 8 (1) (b) states that where the Act requires the licensee to have, institute and otherwise put in place a procedure , the licensee is required to ensure that the procedure is complied with.
The licensee failed to comply with their complaints policy # RCA-LTCE-E-09 revised April 2013.
Review of the licensee's complaint policy indicates:
The Administrator will respond in writing to all written complaints within 10 business days of the receipt of the complaint and provide a follow up response to the person who made the complaint. This response must include either what the home has done to resolve the complaint or the outcome that the home believes the complaint to be unfounded and the reasons for this belief.
A review of the licensee's Complaint Log indicated that on October 21, 2013, the Power of Attorney(POA) for Resident #5831 verbally discussed a concern that the resident's POA believed adversely affected the care of the resident.
The Complaint Log indicates that on October 24, 2013, the POA left a written of concern letter regarding the conversation of October 21, 2013.
Interview with the POA on May 13, 2014 and review of the licensee's documentation related to the complaint, indicated that a letter of response has not been received by the POA. [s. 8. (1) (b)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 12. Furnishings

Specifically failed to comply with the following:

s. 12. (2)The licensee shall ensure that,
(a) resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care; O. Reg. 79/10, s. 12 (2).
(b) resident beds are capable of being elevated at the head and have a headboard and a footboard; O. Reg. 79/10, s. 12 (2).
(c) roll-away beds, day beds, double deck beds, or cots are not used as sleeping accommodation for a resident, except in an emergency; O. Reg. 79/10, s. 12 (2).
(d) a bedside table is provided for every resident; O. Reg. 79/10, s. 12 (2).
(e) a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so; and O. Reg. 79/10, s. 12 (2).
(f) a clothes closet is provided for every resident in the resident's bedroom. O. Reg. 79/10, s. 12 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a comfortable easy chair has been provided for Residents #5801,#5802,#5804 and #5833 in the residents' rooms.
From May 6 to May 9, 2014 and from May 12 to May 14,2014, Inspector #166 observed that Resident #5801, #5804 and #5833's bedrooms did not have a easy chair provided for the residents.
There is no documentation to indicate that the residents/or the residents' Substitute Decision Makers had declined to have a comfortable easy chair provided. [s. 12. (2)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to immediately forward a written complaint concerning the care of a resident to the Director.
Review of the Licensee's complaint log indicated that the Acting Administrator had received a written letter of complaint dated October 24, 2013 from the Power of Attorney(POA) for Resident #5831. The complaint letter outlined a series of events that the POA believed adversely affected the care of Resident #5831.
There is no evidence that the licensee has forwarded the written complaint the Director. [s. 22. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that no resident who requires assistance with eating and drinking is served a meal until someone is available to provide the assistance required by the resident.
On May 6, 2014, during the lunch service, Inspector #571 observed that food was served to three residents, who required feeding/assistance with meals. The Inspector noted the residents' meals sat on the table for at least 5 minutes as no one was available to assist these residents.
A Manager notified PSW #101 that a meal had been served to a resident and no one was feeding the resident. The PSW took the food back to the servery to be kept warm until someone could assist/feed the resident. [s. 73. (2) (b)]

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

Issued on this 30th day of May, 2014

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

Caroline Tompkins #166.

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CAROLINE TOMPKINS (166), MARIA FRANCIS-ALLEN (552), PATRICIA BELL (571)
Inspection No. / No de l'inspection :	2014_195166_0014
Log No. / Registre no:	O-000380-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 13, 30, 2014
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 McKay

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

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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 :

O.Reg 79/10, 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, and those doors must be kept closed and locked when they are not being supervised by staff.

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; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee shall ensure that 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.

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

Grounds / Motifs :

1. The licensee failed to ensure that a door leading to an outside area is equipped with locks to restrict unsupervised access to the area by residents.
On May 6, 2014, during the initial tour of the home, Inspector #571 observed that the door in the physio room opened to the outside. The door did not have a locking mechanism in place and could allow residents to exit into a large outdoor area that is unsupervised.
The Administrator was notified on May 6, 2014 and a temporary locking mechanism was put into use on the door leading into the physio room.
Interview with the Administrator and the Director Care indicated that residents have not used that door to exit to the outside. (166)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 20, 2014

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
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 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
Performance Improvement and Compliance 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 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
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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 30th day of May, 2014

Signature of Inspector / Signature de l'inspecteur : Caroline Tompkins

Name of Inspector / Nom de l'inspecteur : CAROLINE TOMPKINS

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