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 prévue le Loi de 2007 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

Ottawa Service Area Office
347 Preston St 4th Floor
OTTAWA ON L1K 0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston 4iém étage
OTTAWA ON L1K 0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Apr 07, 2015;	2015_330573_0005 (A1) (Appeal\Dir#: Appeal/Dir#: DR #41)	O-001472-15	Resident Quality Inspection

Licensee/Titulaire de permis

CITY OF OTTAWA
Long Term Care Branch 275 Perrier Avenue OTTAWA ON K1L 5C6

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

CARLETON LODGE
55 LODGE ROAD R. R. #2 NEPEAN ON K2C 3H1

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

JESSICA LAPENSEE (133) - (A1)(Appeal\Dir#: Appeal/Dir#: DR #41)

Amended Inspection Summary/Résumé de l'inspection modifié

This report has been revised to reflect a decision of the Director on a review of the Inspector's order, #001. The Director review was completed on April 1, 2015. The order was altered to reflect the Director's review. The compliance date of order #001 has been extended to June 8, 2015.

Issued on this 7 day of April 2015 (A1)(Appeal\Dir#: Appeal/Dir#: DR #41)

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

Original report signed by the inspector.

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JESSICA LAPENSEE (133) - (A1)(Appeal/Dir# Appeal/Dir#: DR #41)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): January 26,27,28,29,30 and February 2,3,4 and 5, 2015

Critical Incident Inspection Log (s) # O-000316-14, O-000317-14 and O-000828-14 were also inspected during the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with residents, family members, several personal support workers (PSWs), several housekeeping aides, several maintenance staffs, a alarm technician, a food service worker (FSW), a Physiotherapy Assistant, several registered practical nurses (RPNs), several registered nurses (RNs), the Pharmacist, the Physiotherapist, the program administration clerk, the President of the Residents' Council, the President Family and Friends Council, the Facilities Supervisor, the Food Services Supervisor ,the RAI-MDS Coordinator, the Manager of Hospitality Services, the Manager of Recreation, Leisure & Volunteer Services, the Manager of Personal Care, the Manager of Resident Care and the Administrator.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

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

- **15 WN(s)**
- **10 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	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 #2: The Licensee has failed to comply with O.Reg 79/10, s. 14. Every licensee of a long-term care home shall ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall. O. Reg. 79/10, s. 14.

Findings/Faits saillants :

1. The licensee has failed to ensure that every Resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall.

Inspector #573 observed the resident shower rooms at the Goulbourn Village unit in the Richmond Road and Stittsville Road were only equipped with one grab bar adjacent to the wall. The wall beside the faucet did not have a grab bar.

In Rideau Village unit, the shower room in the Manotick Road were only equipped with one grab bar adjacent to the wall. The wall beside the faucet did not have a grab bar.

In Nepean Village unit, the shower room in the Jockvale Road is equipped with one grab bar beside the faucet. The wall adjacent to the faucet did not have a grab bar.The shower room in Fallowfield Road were equipped with one grab bar adjacent to the wall. The wall beside the faucet did not have a grab bar.

In West Carlton Village unit, the shower room in the Carp Road is equipped with one grab bar beside the faucet. The wall adjacent to the faucet did not have a grab bar.The shower room in Kinburn Road were equipped with one grab bar adjacent to the wall. The wall beside the faucet did not have a grab bar.

On February 03, 2015 the Manager,Hospitality Services who is in-charge of the Home's environmental services agreed with Inspector #573 that the shower rooms identified by the Inspector did not meet the legislative requirements of s.14 related to shower grab bars. [s. 14.]

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 resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s.37 (1)(a), whereby the licensee did not ensure that each resident of the home has his or her personal items, labeled within 48 hours of admission and of acquiring, in the case of new items.

During the Resident observation Inspector (s) #573 and #547 observed the following unlabelled resident personal items within the shared resident washrooms in various units of the home.

In Goulbourn village unit:
2 hair combs (used) and 1 mouthwash
1 white toothbrush, 1 toothpaste in a blue basin on the sink counter and 1 black comb,
1 pink hair brush (used) with no name
1 black hair comb (used) and 1 white tooth brush

In West Carleton village unit:
2 toothbrushes in a white cup on the side of the sink counter
2 hairbrushes (used), 3 toothbrushes in a blue basin on the side of the sink counter, 2 used deodorant sticks inside a green kidney basin

In Nepean village unit:
1 deodorant stick (used), 2 used hairbrushes, 1 used black color hair comb, 1 petroleum jelly with no name and 2 white colours used toothbrushes

On January 27, 2015 Inspector #138 observed the following personal items in the Rideau village unit Spa room without a label:

1 comb with visible hair
1 roll on deodorant (used)
1 used unlabeled toothpaste
1 used bar of soap
2 used Razors

On February 02, 2015 Inspector #573 interviewed the Manager for Resident Care who stated that the Home's expectation is that all the residents' personal care items especially in shared rooms are to be labeled by the PSW staff members. [s. 37. (1) (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 each resident of the home has his or her personal items, including grooming and hygiene products labeled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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 comply with section 15(2)(c) of the Act in that the home and furnishings are not maintained in a safe condition and in a good state of repair.

Inspector #138 toured the home on February 3, 2015 and again on February 4, 2015 and observed the following:

-The vertical edges on the outside of the communication station at each of the four home areas were in disrepair in that the surface has peeled away and was chipped, exposing a rough surface with sharp areas that were in areas frequently accessed by residents.

Rideau Village unit:
-Fifteen resident bedside tables were identified to be heavily chipped along the top front and side edges exposing the particle board which resulted in the table tops having rough and porous surfaces that were both a safety concern and a cleaning concern.
-Three chairs in the resident lounge area had wooden arm rests and legs in which the finish was worn off and the bare wood was exposed.
-The flooring in the hallway on Kars was observed to be cracked in multiple places on both sides of the corridor near the walls. It was also observed at the end of hallway on Kars that there was a square metal access plate in the floor where the surrounding flooring was chipped away exposing the concrete beneath. The nearby flooring by the emergency exit was in disrepair as it had lifted and was cracked in several places including the baseboards.

West Carleton Village unit:
-The heater and walls by the patio door in the home area dining room were gouged and scuffed with black marks.
-The flooring in the hallway on Carp was cracked in many places and the backing of the flooring was visible through many of the cracks. Specifically there were four cracks each approximately four inches in length in the flooring outside the dining room. There was an approximate five foot crack outside the door to room 37. Outside room 36, there was a t-shape cracked in the floor in which each line was approximately one foot long and the backing was visible through the cracks. There was another one foot crack outside room 35 in which the backing was also visible. Nearby there were multiple cracks, one to two inches in length, that covered a five foot section in which duct tape had been applied.

Nepean Village unit:
-The dining room flooring that curls up into a baseboard in the areas by both patio doors was cracked at all the corners. The flooring that curls up into the baseboard was no longer adhered to the wall in the area under the posted daily menu.
-A portion of the flooring outside the shower room was torn, exposing the wooden floor beneath.
-Room 3 had an unfinished area on the wall behind the toilet in the resident's washroom in which the unfinished drywall and the wood flooring was exposed.
-Room 29 had holes in the drywall behind the toilet in the resident's washroom.
-Room 31 had a portion of the baseboard in the resident's washroom that was no longer attached.

-The ceiling in the sitting room has a square section of repair that has not been completed. In addition there is some discolouration suggestive of subsequent moisture damage in the corner.

The Inspector spoke with the Facilities Supervisor on February 3, 2015, and he stated that the home has replaced and repaired much of the flooring and further stated that replacing the flooring on West Carleton village unit and the entrance flooring to the shower and spa room on Nepean village unit are the next projects planned for the home.

The Inspector also spoke with the Manager, Hospitality Services on February 4, 2015 who stated that many pieces of furniture have already been replaced but that more are to be replaced in the upcoming year. Further, she stated that she has a pre-approved budget to purchase twenty three new bedside tables as well as a loveseat and lounge chairs for Rideau village unit. [s. 15. (2) (c)]

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 the flooring in Rideau and West Carleton Village as well as the furniture in Rideau Village is in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee failed to comply with section 31.(1) of the Act in that the licensee failed to ensure that a resident may be restrained by a physical device if the restraining of the resident is included in the resident's plan of care.

Resident #007 was observed on two separate occasions to be seated in a wheelchair with a lap belt applied. The resident's plan of care, as defined by the home, was reviewed and there was no indication that the resident was to wear a lap belt. The inspector spoke with a PSW on the resident's home area, Staff #114, and the PSW stated that the resident normally wears a lap belt and further stated that the resident is unable to release the lap belt. Resident #007's health care record was further reviewed and it was noted on the November 2014 medication administration records that the lap belt restraint was discontinued on a specific day in October 2014. Also, the progress notes in the health care record stated that the lap belt restraint was discontinued on a specific day in October 2014.

The inspector spoke with the home area RN, Staff #112, regarding the lap belt that was observed to be applied to Resident #007. The RN stated that the resident is not to wear a lap belt and confirmed that the lap belt restraint was discontinued in October 2014. The RN further stated that the lap belt was applied by staff even though it had been discontinued because the lap belt is physically attached to the wheelchair and available to the staff. [s. 31. (1)]

2. Critical Incident System Report #M508-000014-14 was reviewed and stated that an incident that caused injury to a resident for which the resident was taken to hospital and which resulted in a significant change in condition had occurred on a specific day in August 2014 involving Resident #041.

A review of Resident #041's health care record indicated that the resident had experienced a fall on a specific day in August 2014 that resulted in transfer to hospital for a fractured hip. Prior to the fall Resident #041 had been ambulating independently.

In an interview on February 4, 2015 RPN Staff #134 stated that because Resident #041 was at a very high risk for falls, the resident was now confined to a wheel chair with a seat belt restraint.

On February 4, 2015 Inspector #556 observed Resident #041 attending an activity in the unit dining room, the resident was seated in a wheel chair with a seat belt in place.

In an interview PSW Staff #136 stated that Resident #041 was cognitively and physically incapable of removing the seat belt restraint.

Resident #041's Plan of Care was reviewed and there was no indication that Resident #041 required a seat belt restraint. [O-000828-14] [s. 31. (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 no resident is restrained by a physical device unless the restraining of the resident is included in the Resident's plan of care, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to comply with section 71(4) of the regulation in that the licensee failed to ensure that the planned menu items are offered and available at each meal and snack.

Inspector #138 observed the lunch meal service in Rideau village unit on January 26, 2015. The inspector noted that the menu posted stated that whole wheat bread is to be offered at all meals while the therapeutic menus also stated that pureed bread is offered at meals for the puree menu. During the meal service, it was observed that there was a plate of buttered bread slices on the counter in the servery but noted that the bread had not been offered to any of the residents in the dining room during the meal service. The inspector spoke with the food service worker, Staff #123, regarding the bread and pureed bread and the food service worker stated that the bread was available for those who requested it but that the pureed bread was no longer available as the residents grew tired of it.

The inspector spoke with the Manager, Hospitality Services who stated that bread, including puree bread, is to be offered at all meals and is to be plated with the meal that is delivered to the resident.

The Inspector reviewed the Residents Food Committee Meeting minutes and noted that both the May 28, 2014 and July 23, 2014 minutes documented concerns by residents that bread was not being offered at meals. [s. 71. (4)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee failed to ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

Privacy curtains in a number of semi-private rooms were noted to be insufficient in providing privacy to residents. Specifically, it was noted that in semi-private rooms 1-R, 36-R, 1-G, 36-G, 1-WC, 38-WC, 1-N, and 38-N that the privacy curtains for Bed 1 would not afford privacy when there was movement of individuals from Bed 2 to the shared washroom or to the door of the room. This insufficient privacy was related to the layout of the tracks for the privacy curtains. Additionally, it was also noted that the track for the privacy curtains of Bed 1 in rooms 36-R, 36-G, 38-WC, and 38-N were not long enough and this caused an approximate two foot opening at the entrance of the room even when the privacy curtains were fully extended. Further, it was noted in 1-WC Bed 2 that one of the two privacy curtains had an upper mesh panel that allowed visibility into the area from the chest level up. This was also the case in room 38-N Bed 2 where both privacy curtains had a larger upper mesh panel that allowed visibility into the area from the chest level and up. Finally, room 38-WC Bed 2 had a privacy curtain that was not long enough to fully extend in the track resulting in a two foot opening when the privacy curtain was fully extended. The Inspector toured the above mentioned rooms with the Manager, Hospitality Services. [s. 13.]

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 residents in semi-private rooms are provided with sufficient privacy curtains, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to comply with section 17(1)(a) of the regulation in that the licensee failed to ensure that the communication and response system (call bell system) can be easily accessed and used by residents at all times.

Inspector #138 was on specific unit mid-morning January 28, 2015 and noted that Resident #001 and Resident #010 were in their private rooms, sitting in their respective wheelchairs, and that the call bell cord that is used to engage a signal to activate the call bell system was not within reach of either resident.

The Inspector proceeded into the room of Resident #001 and spoke with the resident. The resident, who was assessed to be cognitively aware by the inspector, stated that she/he is blind and gets upset because she/he can not find the call bell as staff do not routinely provide it to her/him. The resident further stated that she/he needs to ask staff for the call bell in order for it to be provided. It was observed by the inspector that the resident's call bell was coiled up on the resident's bed, out of reach from the resident who was sitting in a wheelchair. It was also noted that the call bell was beige and blended in with the beige comforter on the resident's bed making it hard to identify by someone who is visually impaired. The resident stated that she/he could not see the call bell and asked the inspector to provide it to her/him.

The Inspector then proceeded into the room of Resident #010 and observed that the

resident was sitting in a wheelchair several feet from the bed and was watching TV. The resident was able to converse with the inspector and asked the inspector to assist in moving her/his wheelchair. The inspector asked the resident if she/he could reach the call bell for assistance in which the resident replied that she/he could not. The resident further stated that staff did not usually provide her/him with the call bell. The inspector, who noted that the call bell was on the resident's bed several feet away, obtained the call bell, rang it, and then provided the call bell to the resident.

Mid-morning on February 3, 3015 the Inspector again proceeded to Resident #010's room and noted that the resident was sitting in her/his wheelchair watching TV. The inspector again noted that the call bell was coiled up on the bed several feet away from the resident.

Also, on February 3, 2015 the inspector was on specific unit at approximately 11:30 am and saw Resident #048 sitting in a wheelchair with an attached table top, watching TV in her/his room. The inspector went into the resident's room and noted that the call bell was sitting on the resident's bed, out of reach of the resident. The inspector spoke with the resident who indicated that she/he was not able to reach the call bell, that staff did not usually provide her/him the call bell, and that she/he would like to have access to the call bell. The inspector provided the resident with the call bell.

In addition, on February 3, 2015 it was observed that the resident designated washrooms located outside the dining room on Rideau, West Carleton, and Goulbourn units had call bells that were not accessible to residents who may be seated on the toilet. The call bell stations in these washrooms were located by the light switch near the entrance of the washroom and attached to the call bell station was a pull cord that was long enough to reach across the washroom to the toilet. However, during the observations it was noted that the call bell pull cords were wrapped up and placed on the counter directly below the call bell station. In this position, the call bell pull cord would not be accessible to a resident seated on the toilet. [s. 17. (1) (a)]

2. The licensee has failed to ensure that the resident-staff communication and response system (the system) is available in every area accessible by residents

On January 27, 2015 at 12:08 pm, Inspector #133 entered the Country Kitchen on the second floor of the home, with Inspector #547. The country kitchen is a resident accessible room in which there is a domestic style refrigerator and stove, a sink, storage cupboards above and below the sink counter, a dining room table with 6 chairs and a stand-alone shelf unit. While making observations within the space, it

was noted that the call bell system was not available anywhere within the room.

Within the same general area of the Country Kitchen, on the second floor, there is a Beauty Salon. On January 27, 2015, after making observations within the Country Kitchen, Inspector #133 entered the Beauty Salon and noted that the system was not available anywhere within this room.

On January 28, 2015, Inspector #133 met with the home's Facility Supervisor(FS) and discussed the absence of the system within the Country Kitchen and Beauty Salon. The FS explained to the Inspector that within the last year, an upgrade of the system occurred. He explained that the system upgrade was managed by project planners with the City of Ottawa and that he was not involved. He revisited the two areas with the Inspector #133, and it was speculated that the absence of the system may have been an oversight.

Inspector #133 found that the system was available in all other areas accessible to residents. [s. 17. (1) (e)]

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 1)the resident-staff communication and response system can be easily accessed and used by residents at all times. 2)the resident-staff communication and response system be available in every area accessible by residents,specifically, in the Country Kitchen and Beauty Salon, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007, 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:
2. Every resident has the right to be protected from abuse. 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:
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to fully respect and promote Resident #043's right to be protected from emotional abuse.

O. Reg 79/10, s. 2. (1) defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Critical Incident System Report #M508-000006-14 was reviewed and stated that an incident of staff to resident abuse occurred on a specific day in March 2014 involving Resident #043.

In an interview Resident #043 stated that on a specific day in March 2014, PSW Staff #106 wrapped the resident in a bed sheet with only a continence product underneath and even though he/she objected and stated that he/she wished to have the pants on, the PSW Staff #106 took the resident into the dining room for the breakfast. Resident #043 stated that he/she was then taken for a shower after which he/she was left in the hall wrapped in the bed sheet until lunch time when he/she was again taken to the dining room still wrapped in the bed sheet. Resident #043 stated that he/she was quite clear that he/she did not wish this to happen and the resident felt very embarrassed and humiliated by the experience.

A review of Resident #043's health care record indicated in a progress note on a specific day in March 2014 stated "the resident had his/her shower today. Unable to get resident's pants on resident as used mechanical lift and no toileting sling".

In an interview the Program Manager of Personal Care (PMPC) stated that she was away on training at the time of the incident and the Program Manager of Resident Care (PMRC) was covering for her during that time. The PMPC stated it is not appropriate at any time for a resident to be taken to the dining room wrapped in a sheet, or to be left sitting in the hall wrapped in a sheet. She stated that this type of treatment of a resident is considered to be emotional abuse. The PMPC further stated that she conducted the internal investigation into the incident and found that the resident had asked to have his/her pants on but the staff did not comply with his/her wishes. She stated the resident reported the incident to the Registered Nurse on a specific day in March 2014. She further stated that 3 staff members including 2 PSW's and 1 RPN were involved in causing the emotional abuse to the resident and all 3 employees received discipline for their part in the emotional abuse to Resident #043.[O-000317-14] [s. 3. (1) 2.]

2. The licensee has failed to fully respect and promote every resident's right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

This is related to an identified resident, who was not allowed to leave the building, in the name of outbreak management. As well, this is related to the home's practice of closing and locking unit doors. The identified units are not designated as secure units.

The LTCHA, 2007, S.O 2007, c. 8, s. 30 (1) 5. prescribes that the licensee must ensure that no resident of the home is restrained, by use of barriers, locks, or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents. There are exceptions to this provision, which do not apply to the identified care units or scenarios described below.

On January 27, 2015 Inspector #133 was made aware that the Goulborne Village (GV) unit was considered to be experiencing an outbreak of respiratory illness. While this unit is not a designated secured unit, the doors in and out of the unit were being kept closed and locked in the name of outbreak management. To unlock the doors, an access swipe card is required. At approximately 9:50am, on January 27, 2015 RN Staff #117 stated to Inspector #133 that the doors had been closed and locked as of January 26, 2015 and this was the normal practice when an outbreak is declared. The RN Staff #117 stated that residents are not allowed to leave the unit unsupervised and confirmed that none of the residents have an access swipe card. The RN stated that resident's families have access cards, and they were allowed to come in and take

a resident directly out of the building. The RN explained to the Inspector that one of the Program Managers had directed that the doors be closed and locked. At 10:17am, in the Stitsville Road hallway, within the GV unit, Inspector #133 spoke with a PSW Staff #121 who explained to Inspector #133 that there was 1 resident affected by the respiratory illness. She stated that they do not want residents to leave the unit, and she was not sure if residents were allowed to leave the building. The PSW Staff #121 informed Inspector #133 that there are a few residents within GV unit that normally do leave the unit independently. The PSW Staff #121 informed that Resident #045 is one such resident.

On January 27, 2015 at 11am, Inspector #133 met with the Program Manager of Personal Care (PMPC), who is also the home's designated lead for the Infection Prevention and Control Program. The PMPC confirmed that when there is an outbreak on the Goulborne Village unit, the doors are closed and locked in order to prevent any resident from leaving the unit unsupervised. The PMPC confirmed that GV is not a secured unit. The PMPC confirmed that there has been no quarantine order issued to the home by the local Medical Officer of Health. As well, the PMPC explained to Inspector #133 that they did not feel that closing and locking the GV unit doors was any different than the home's routine practice of closing and locking the doors to the West Carleton Village and Nepean Village units every night at 8pm.

On January 27, 2015 at 2pm, Inspector #133 met with Resident #045, who resides on the GV unit. The Inspector informed the resident that they had been told that the resident normally leaves the unit unaccompanied. Resident #045 confirmed this, explaining that she/he like to go to the tuck shop. Resident #045 said that she/he is not allowed to leave the unit now, due to the outbreak. Resident #045 explained to the Inspector that it was their understanding that they are not allowed to leave the home either. Resident #045 explained that normally on an identified day of the week they go to visit a sibling, and on another identified day of the week, they go bowling. The resident told the Inspector that the night before, a RPN Staff #129 and a RN Staff #130 had told her/him that she/he was not allowed to leave the home for these outings. The resident communicated that it was very important to them that they be seen as following the home's rules. Inspector #133 was later informed, during conversation with the home's Program Managers that there is a complex history between this resident and their family with regards to rules. The Program Managers were informed that Resident #045 understood that she/he was not allowed to leave the building.

On January 27, 2015 at 4:26pm, Inspector #133 met an RPN Staff #124, in the GV

unit. The RPN told the Inspector that because only one resident was affected by the respiratory outbreak, the unit was not truly in outbreak, only on precautions. The RPN told the Inspector that if it was a true outbreak, residents are not allowed off the unit, and residents are not allowed to leave the home, as they don't want the residents to spread things around. The RPN said that when in the precaution stage, it's just that they don't encourage residents to leave the unit or visitors to come in to the unit, but if they want to they have the right to do so. Inspector #133 later confirmed that the GV unit had been officially declared in respiratory outbreak, by the local Health Unit, because although there was only 1 case, the other first floor unit (Rideau Village, RV) was in respiratory outbreak, and the one case in GV was being considered as a continuation of the RV outbreak.

On January 27, 2015 at 4:50pm, Inspector #133 met an RPN Staff #125 on the 2nd floor West Carleton Village (WCV) unit. The WCV unit is not a designated secured unit. Inspector #133 asked the RPN if the unit doors are closed and locked as of 8pm. The RPN brought Inspector #133 to the card reader at the door and explained that at 8pm, the green light turns to red, which means if the door is closed, it will be locked. The RPN explained they have no control over this timing, so if they want to close the doors, they are locked. The RPN explained that there are a few residents on the WCV who exhibit high risk wandering behaviour and can be very unsettled at night, so she feels she has to keep the unit doors closed to keep these residents within the unit. The RPN specified that it doesn't happen every night, and when it does, sometimes she will open the doors again if the wandering residents have settled into bed. The RPN indicated if a resident, who was okay to be out and on their own, asked her to let them out, she would do so.

Inspector #133 spoke with Resident #046, within the WCV unit, about the door security at night. Inspector #133 had seen this resident in several different locations of the home, unaccompanied, during the course of that day. Inspector #133 asked if it was the case that the doors are closed and locked at night and the resident confirmed that they are. Inspector #133 asked the resident what they do if they want to leave the unit and the doors are closed and locked. Resident #046 replied that they may ask staff to let them out, or that they may just go back to their room.

On January 27, 2015, at approximately 5:15pm, Inspector #133 met an RPN Staff #126, on the 2nd floor Nepean Village (NV) unit. The NV unit is not a designated secured unit. Inspector #133 asked the RPN if the unit doors are closed and locked as of 8pm. The RPN qualified that the NV unit is not her full time unit, but her understanding is that she is to close the doors as of 8pm. The RPN explained that

there are some wandering residents on the unit, and that they need to keep them on the unit at night so they can receive the care they need, as scheduled. The RPN indicated that a few residents do have access cards, but only those residents who are deemed safe to leave the home unaccompanied, as per an agreement with the family.

On January 28, 2015 at 9:24am, Inspector #133 met with the home's Program Manager for Personal Care (PMPC) again. Inspector #133 asked the PMPC to clarify why it was that the doors to the 2nd floor care units, which are not designated as secured unit, were being closed and locked as of 8pm. The PMPC indicated that she had no explanation, and stated that it was simply something that had always been done. The PMPC asked if the other Program Manager could be brought into the discussion. Inspector #133 and the PMPC then met with the home's Program Manager for Resident Care, the PMRC explained to the Inspector that the reason they close and lock the doors is that there are residents who get admitted to these units that actually need a bed in the secured unit, due to their wandering behaviour. The PMRC explained that information available to them at the time of admission does not always fully describe such behaviours or identify all risks. Inspector #133 indicated that it was their understanding that staff at the home have no ability to change the time a door would be locked. The Program Managers (PMs) confirmed this, and explained that on the main level, the Goulborne Village doors are programmed to be locked anytime they are closed. In the two 2nd floor units, the doors lock only after 8pm. The PMs asserted that it wasn't their intention to lock all the residents in, but they have no choice if the doors are closed. The PMs explained that this is all managed off site, within the City of Ottawa Corporate Security Operations Centre, at 101 Centre Point Drive.

On January 28, 2015 at 10:03am, Inspector #133 met with the home's Administrator. Inspector #133 informed the Administrator that they had a concern about the Goulborne Village (GV), West Carleton Village (WCV), and Nepean Village (NV) unit doors being kept closed and locked. As well, Inspector #133 informed that it appeared that the home's staff had no ability to change the time that doors will be locked, if they are closed. The Administrator indicated that he had not been aware that this was happening, and reflected that none of the 3 units were designated as secured units. He advised the Inspector that he was going to contact a City of Ottawa security advisor about the doors. Around noon that day, the Administrator sought out Inspector #133, advised that he had been in touch with a security advisor, and that he had learned that he could request a change in the time that any of the care unit doors are locked if closed. He advised he would request that the doors not be locked when they

are closed, with the exception of the designated secure unit, Rideau Village. On February 4, 2015 the Administrator explained that his request had been processed within a few hours. It was observed that although the GV doors were still being kept closed, in the morning, the doors were no longer locked. The Administrator explained that now, when the WCV and NV doors are closed, they will not be locked.

On February 4, 2015 at approximately 4:30pm, Inspector #133 met with RN Staff #130, that Resident #045 had referred to on January 27, 2015. The Inspector explained to the RN that resident #045 had told the Inspector that the RN had told them that they were not allowed to leave the building for outings, such as to visit their sibling or to go bowling, because of outbreak control measures. The RN confirmed that was accurate, and explained that it was required as they did not want residents spreading things around. [s. 3. (1) 13.]

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 resident's right not to be restrained, except in limited circumstances provided for under this Act and subject to the requirements provided for under this Act, are fully respected and promoted, as it relates to outbreak management, care unit doors, and resident's participation in activities outside of the home, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect abuse of Resident #043 by staff that resulted in harm or risk of harm to the resident immediately reported the suspicion and information upon which it was based to the Director.

O. Reg 79/10, s. 2. (1) defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Critical Incident System Report #M508-000006-14 was reviewed and stated that an incident of staff to resident abuse occurred on a specific day in March 2014 involving Resident #043.

In an interview the Program Manager of Personal Care (PMPC) stated that it is not appropriate at any time for a resident to be taken to the dining room wrapped in a sheet, or to be left sitting wrapped in a sheet in the hall. She further stated that this treatment of a resident is considered to be emotional abuse. The PMPC further stated that at breakfast and lunch there would have been 1 RN/RPN, 3 PSW's, and 2 dietary staff and that any of those staff members would be expected to report the emotional abuse of a resident. She further stated that during the internal investigation into the

incident PSW Staff #115 stated that she wasn't comfortable with Resident #043 not being given his/her pants, however because PSW Staff #115 did not take further action on behalf of the resident PSW Staff #115 received discipline. PMPC stated that at the very minimum PSW Staff #115 should have reported the incident to the charge nurse. The PMPC further stated that RN Staff #107 was advised of the incident on a specific day in March 2014 and the expectation of the home is that RN Staff #107 would report the incident right away to a Nursing manager.

In an interview with the Program Manager of Resident Care (PMRC) who was covering for the PMPC during the time of the incident stated that she could not remember if RN Staff #107 reported the incident to her on a specific day in March 2014 or not. The PMRC reviewed her file related to the incident and was not able to locate any notes prior to a specific day in April 2014.

In an interview RN Staff #107 stated that on specific day in March 2014 she spoke with Resident #043 and was advised of the incident and she reported it to the PMRC that same day. She further stated that she was told by the PMRC to put the details of the incident in writing, which she did.

The Critical Incident System Report #M508-000006-14 was reviewed and it was noted that the incident occurred on specific day in March 2014 and was not reported to the MOHLTC until a specific day in April 2014 ,which is approximately 5 days after the incident. [O-000317-14] [s. 24. (1)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any follow-up response or any acknowledgement or investigation regarding the lost item was provided to the complainant prior to this RQI Inspection.

On January 29, 2015 Inspector #556 conducted a interview with Resident #31's family member who indicated that she/he reported the lost item to RN Staff #107,PSW Staff #120, and a housecleaning staff member on the unit however nothing was ever written down to take it seriously, and she/he never received any response from anyone in the home to this date.

On February 3, 2015 Inspector #547 interviewed RN Staff #107 who reported that she did remember receiving the complaint from Resident #31's family member about the lost item of the Resident that had disappeared, however she did not complete a formal lost item form or any formal acknowledgement of this complaint.RN Staff #107 further indicated that a follow-up response was not made to the complainant about the home's investigation to this lost item prior to this inspection. [s. 101. (1) 2.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The Licensee has failed to ensure that steps are taken to ensure the security of the drug supply, including the following:

1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to, i. persons who may dispense, prescribe or administer drugs in the home and the Administrator.

On Tuesday January 27, 2015 at 12:45 Inspector #556 observed RPN #102 leaving a medication cart unlocked and unattended in the hall outside the Nepean Village dining room. When approached by Inspector #566 RPN #102 stated that the lock on the medication cart was not working.

RN #107 was advised that the medication cart was not locking and stated that a MediSystem technician comes to the home every Friday to inspect the medication carts but that she would call MediSystem and report that the cart was not locking properly and have the technician come to the home right away.

On Monday February 2, 2015 at 12:17 Inspector #556 observed RPN #126 leaving a medication cart unlocked and unattended in the hall outside the Nepean Village dining room. RPN #126 stated that the cart is supposed to lock automatically but the lock wasn't working.

RN #107 was again advised that the medication cart was not locking and stated that the MediSystem technician had been in the home on Friday, January 30, 2015 and the medication cart was inspected at that time. RN #107 then timed the automatic locking mechanism on the medication cart and stated that there was definitively something wrong with the cart because the lock was taking 1 minute and 50 seconds for the automatic lock to engage, she then proceeded to call MediSystem to report the malfunction of the automatic locking mechanism.

In an interview the Program Manager Personal Care (PMPC) stated that the medication carts are set up to lock automatically after 2 minutes and all registered staff are trained not to leave the medication cart unattended until the lock has engaged.
On January 27 and February 3, 2015 Inspector (s) #573 and #556 observed a container of prescription cream in a bin in Resident #017's bathroom that she/he shares with another resident. A review of the physician's orders on Resident #017's health care record indicated that on a specific day in January 2015 the prescription cream was ordered and was to be used.
Also on January 27 and February 3, 2015 Inspectors #573 and #556 observed a partially used tube of Voltaren gel in a bin in Resident #011's bathroom. A review of the physician's orders on Resident #011's health care record indicated that voltaren emulgel was to be applied to affected areas daily.

In an interview RN #117 stated that Personal Support Worker's (PSW) have been trained on the application of topical medications and are allowed to apply them as directed. RN #117 stated that the topical medications are stored in the medication cart or the medication room and the RN/RPN's provide the PSW's with access to the topical medications as required. RN #117 stated that the prescription cream and/or the voltaren gel should not have been left in resident bathrooms because there are residents on the unit that wander into other resident's rooms and for safety reasons the prescription cream and the voltaren gel should be stored in the medication cart or the medication room.
RN #117 opened the locked medication room and Inspector #556 observed a bin containing topical medications for resident's on the unit.
In an interview RPN #102 stated that certain topical medications are applied by the PSW's if a nursing assessment is not required, however all topical medications are to be returned to the bin that they are kept in and not left in resident rooms. [s. 130. 1.]

2. On February 3, 2015 Inspector #547 observed a City of Ottawa staff member enter the locked medication room on the West Carleton unit with an access swipe key.On

this same date, Inspector #547 interviewed RN Staff #101 regarding the City of Ottawa staff member #135 who entered the locked medication room and confirmed that he was not a person who may dispense, prescribe or administer drugs in the home, or is the Administrator and that he has always had his own access key to the medication rooms in order to deliver medical supplies. RN Staff #101 reported that Staff #135 is not required to ask a Registered Nursing staff member to accompany him while in the medication room.

On this same date, Inspector #547 then interviewed Staff #135 who indicated that he has always had a swipe key for the medication rooms to every unit in this home as this is the location the home has decided to store their medical supplies. Staff #135 was aware that medication is stored and accessible inside this medication room.

Upon observation inside this medication room, Inspector #547 noted that the government stock is not kept locked inside this space, and accessible to anyone who enters this room.

Inspector #547 then interviewed the Manager of Resident Care for Registered Nursing staff who indicated that she was not aware that Staff #135, who is not a person who may dispense, prescribe or administer drugs in the home and had a swipe key to independently access the medication rooms on every unit in this home. [s. 130. 2. i.]

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 medications,including topical medications, are stored in an area or medication cart that is secure and locked at all times, when not in use, to be implemented voluntarily.

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:

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

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 9 (1) 1. iii. in that the licensee has failed to ensure that all resident accessible doors leading to stairways, and all resident accessible doors leading to the outside of the home, other than doors leading to secure outside areas that preclude exit by a resident, are equipped with an audible alarm that allows calls to be cancelled only at point of activation and is connected to the resident-staff communication and response system, or, 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.

At Carleton Lodge, at the main exit/entrance, there is a single inner door and a set of outer sliding doors. The single inner door is kept closed and locked as is required. The door can be unlocked by use of a swipe card, at the card reader on the wall next to the door. In order to ascertain if the inner door was equipped with an audible alarm as required, on January 27, 2015 beginning at 10:33am, Inspector #133 held the inner exit door open for several minutes. No alarm sounded. The home's Program Administration Clerk (PAC) Staff #122 approached the Inspector and explained that the door is not equipped with an audible alarm. The PAC explained that when any door that is secured with a card reader system such as the inner exit door, is open for a certain period of time, an alert will be triggered at the City of Ottawa Corporate Security Operations Centre (CSOC). The CSOC is off site, located within the City of Ottawa building at 101 Centre Point Drive. The PAC explained that when CSOC staff are alerted to a door that has been opened for too long, they are supposed to call the home and notify them. CSOC staff have the ability to cancel the alert and are supposed to do so only after receiving confirmation from the home that the door has been checked. The PAC explained that it is the same set up for all of the home's stairway doors and exit doors.

On January 28, 2015 Inspector #133 spoke with the home's Administrator about the requirement to have applicable doors equipped with an audible alarm as prescribed by O. Reg. 79/10, s. 9 (1) 1. iii. The Administrator informed that on February 2, 2015 the new audible alarm system and set up would "go live". He explained that they were presently working on information and education for all staff about the new set up and how to cancel a sounding alarm. He explained that the audible alarms would be connected to the resident-staff communication and response system. He explained that within the home, it was expected that the alarms could only be cancelled at the alarming door. Inspector #133 had prior knowledge that CSOC staff have the ability to cancel an audible alarm sounding within the home, as a result of an inspection conducted in another one of the licensee's home on January 14 and 15, 2015 (Inspection # 2015_346133_0001). Inspector #133 informed the Administrator of this

and he indicated that he had not been aware of this issue.

Applicable doors must be equipped with an audible alarm that allows calls to be cancelled ONLY at the point of activation. The point of activation is the door.

On February 3, 2015, at the main reception area, Inspector #133 held the inner exit door open and caused the audible alarm to sound. The door was closed and the alarm continued to sound, as required. Inspector #133 had asked the PAC to contact the CSOC and to explain to them that the Inspector would like them to demonstrate their ability to cancel a sounding alarm remotely. The PAC reached an alarm technician (AT) Staff #131 and he cancelled the sounding alarm when requested to do so. Inspector #133 then spoke with the AT on the phone and asked him to describe how he was able to cancel the alarm. The AT explained that he went into the alarm program, known as Kanetech, on his console, then into the alarm relay section. The AT explained he then highlighted the area related to the sounding alarm and cancelled it.

On February 3, 2015 at approximately 12:04pm, Inspector #133 went into West Carleton Village, down the Kinburn hallway and held the stairway door open in order to activate the audible alarm. The alarm sounded, the door was closed and the alarm continued to sound as is required. Inspector #133 used the RPN Staff #105 ID badge to cancel the alarm. The door alarms have been set up to be connected to the resident-staff communication and response system, and the location of an alarming door should be displayed on the registered nurses' pagers. The RPN indicated to the Inspector that her pager had not received an alert to the alarm. The RN Staff #101, was also in the area and informed that their pager had not received an alert to the alarm.

Inspector #133 spoke with the Administrator about this and he acknowledged that the new alarm system is still very much a work in progress.

On February 5, 2015 beginning at 10:52am, Inspector #133, in the company of a RPN Staff #138, tested the alarm at the stairway next to the main reception desk. The RPN was in possession of pager #RN120 and #RN119. Another RPN, Staff #100, came along while this test was occurring. They were in possession of pager #RN112. While the alarm sounded after the door was held open, as required, the alert did not go through to two of the three pagers. Pager #RN120 and #RN119 did not receive an alert.

As previously noted, the licensee has chosen to connect the audible doors alarms to the resident-staff communication and response system (the system), and all registered staff pagers are to receive an alert to an alarming door. As per O. Reg. 79/10, s. 17 (1) f, the system must clearly indicate when activated where the signal is coming from.

This widespread non-compliance presents a potential risk to residents of the home. [s. 9. (1)]

2. The licensee has failed to comply with O. Reg. 79/10, s.9 (1) 2. in that the licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and that those doors are kept closed and locked when they are not being supervised by staff.

This is specifically related to the door leading into the dish room, which is equipped with a lock, but was not kept closed and locked when not being supervised by staff.

On February 3, 2015 at 11:14am, Inspector #133 observed that the door leading into the main dish room was wide open. There are no barriers in place that would prevent residents from reaching this dish room area. There were no staff present supervising the area. The Inspector could hear someone talking on the phone in the main kitchen, but did not see them, nor did they see the Inspector. The dish room is connected to the main kitchen. In the immediate entrance of the dish room there is a service elevator, which allows unrestricted access to the basement level and into the 2nd floor servery. A variety of cleaning chemicals were observed to be stored in the back corner of the room, past the cart washing area. A few minutes later, the Manager of Hospitality Services (MHS) walked by the room. Inspector #133 stopped the MHS and discussion ensued about the safety risk presented by this situation. The MHS told the Inspector that staff had been directed to close and lock the door when they left the room.

On February 3, 2015 at 4:30pm, Inspector #133 returned to the dish room to further observe the cleaning products stored in the back corner of the room. The door was closed, but not locked. There were no staff present supervising the area. The Inspector could hear people in the main kitchen, but did not see them, nor did they see the Inspector. The Inspector took note of a variety of hazardous cleaning products (classified as toxic or corrosive) on the shelves: EcoLab – High Temp Grill Cleaner, Lime-A-Way, CPS 490, Lemon Lift, Eco Shine, and Wood Wyant Total universal cleaner and polish. A few minutes later, the dish room attendant, Staff #132, came

into the dish room, from the kitchen. They explained that they go back and forth between the kitchen and the dish room during their shift. It was noted that there is no lock on the inside of the door that would allow the attendant to secure the area when they leave and go into the kitchen.

On February 4, 2015 at 3:02 pm, Inspector #133 returned to the dish room and found the door was closed but not locked. There were no staff present supervising the area. The Inspector stayed for 3 minutes and then left to find the Manager of Hospitality Services (MHS). The MHS followed up with the FSS and kitchen staff, and informed the Inspector that the door to the dish room would now be kept closed and locked at all times. The MHS qualified that staff would be allowed to open the door, if it got too hot in the room, as long as they remained in the room. Otherwise, staff would be expected to go through the kitchen to access the dish room. The MHS explained that they would move to securing this door with card reader access, as opposed to the key lock, that quotes were needed and that they anticipated this could be done in about a month. [s. 9. (1) 2.]

3. On January 26, 2015 Inspector #547 observed on the Nepean Village unit, that a Laundry room door was open and unsupervised by any staff member. PSW Staff #106 indicated that this door should have been closed as it is kept locked with a swipe key so residents on the unit do not enter. Inside this laundry room, were tide pods, and liquid purex detergent and a spray bottle with clear fluid inside which indicated bleach written on the bottle with black marker located on a shelf accessible to anyone entering this space. This laundry room door handle was equipped with a locking mechanism and swipe key pad however the door remained open to the main hallway to Nepean Village unit. No audible alarms related to this door were noted.

On February 3, 2015 on the Nepean Village unit, Inspector #547 noted at 11:00, that the door to the room with the laundry chute on this unit was left open which is located on the second floor of the home. This door was equipped with a locking mechanism however the door was not completely closed and could be pushed open. Inside this room, the laundry chute door was also unlocked and open with a chute size of 17.5 inches by 18 inches leading to the laundry room in the basement. Inspector #547 then interviewed PSW Staff #106 who indicated that staff are expected to close this door when they are finished in this space, due to the risk inside this room with the laundry chute that does not lock.On this same date, Inspector #547 interviewed the Facility Supervisor who reported that all the laundry chute rooms should always be closed and locked when unsupervised. Upon observation of the chute itself, there was a key to actually keep this door locked, however the locking mechanism was no longer

functional. The Facility Supervisor indicated that the home's expectation is to keep the main door to the Laundry chute room closed and locked at all times, preventing any resident access to this non-residential area. [s. 9. (1) 2.]

Additional Required Actions:

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

(A1)(Appeal/Dir# Appeal/Dir#: DR #41)
The following order(s) have been amended:CO# 001

WN #10: The Licensee has failed to comply with LTCHA, 2007, 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 has failed to ensure that the home is a safe and secure environment for its Residents.

On January 27, 2015 Inspector #133 conducted a walkabout inspection throughout the home. It was noted that in all care unit dining rooms, there is a servery that is not enclosed in any way. An exception to this is within Rideau Village (RV), the secured unit, where there are storefront accordion doors in place. Inspector #133 noted that within all serveries, on the counter, there is a Douwe Egberts brand tea, coffee and hot water dispenser. There is a caution label on the front face of the machine, indicating that hot liquids are contained within. There is an individual button for each of the three types of liquids. For the tea and coffee, once the button is pressed, the liquid will continue to pour until the red stop button, to the right of the tea and coffee buttons, is pressed. The hot liquid is dispensed quickly. Using dial probe thermometers found within each servery, Inspector #133 measured the temperature of the liquids

dispensed. In the West Carleton Village servery, for example, the tea was 68 degrees Celsius (68 C), the coffee was 74 C and the hot water was 76 C. In RV, the tea and coffee were 75 C and the hot water was 82 C. In RV, although there are the accordion doors in place, which have the ability to be locked, Inspector #133 did not find that these doors were being kept closed or locked. In RV, at 1:40pm on January 27, 2015 Inspector #133 found 5 residents still seated at tables with no staff present. At 1:54 pm, a Food Service Worker (FSW) Staff #123 found Inspector #133 in the servery and acknowledged that the accordion doors are supposed to be kept fully closed, because there are some residents who like to rummage around in the servery. For example, Resident #044 likes to go through things and takes dishes back to their bedroom.

It is noted that on January 26, 2015 mid-morning, Inspector #138 also observed that the accordion doors in the RV servery were only partially closed, with residents in the dining room and no staff present to supervise the area.

On January 28, 2015 in the RV unit, Inspector #133 spoke with the home's Food Services Supervisor (FSS) about the Douwe Egberts hot liquid dispensers within each servery. The FSS showed the Inspector that within the body of the unit, easily accessed by flipping open the front panel, there is an on and off button. The FSS indicated that it had not been the home's practice to secure these hot liquid dispensers. The FSS further explained that in the RV unit, while to servery accordion doors should stay closed when the servery is not supervised, dietary staff do not have a key to the doors and therefore they do not get locked.

It is noted that following the discussion with the FSS, signs were affixed to the dispenser in all care units that indicates the machine is to be turned off when it is not in use, with instructions on how to turn the units on and off.

On February 5, 2015 at 10:02am, Inspector #133 went into the GV dining room and found 4 residents seated at the tables and no staff present and supervising the area. The Inspector observed that the Douwe Egberts hot liquid dispenser was on, despite signage directing staff to turn the unit off when it is not in use. At 10:23am, the Inspector met a FSW Staff #139 in the dining room. The FSW indicated that all staff had been directed to turn the unit off when they leave, after the meal service. The FSW stated that she had not worked on the GV unit this morning. The FSW offered to turn the unit off and was observed to do so by the Inspector.

Liquid at 68 degrees Celsius will cause a third degree burn following 1 second of contact with skin. The legislation that governs the operations of Long Term Care

homes reflects the risk posed by elevated temperatures in that, as per O. Reg. 79/10, s. 90 (2) (h), immediate action is to be taken to reduce the water temperature in the event that it exceeds 49 C. Unsupervised resident access to the Douwe Egberts hot liquid dispensers within each servery is a widespread risk.

On January 27, 2015 Inspector #133 and Inspector #547 entered the Country Kitchen on the second floor and noted that there was a domestic style stove in the room. As well, it was observed that on the wall next to the stove, there was a device labeled as "stove guard". Inspector #133 was able to turn on the stove top elements, and the oven, simply by turning the dials and pressing the oven button. The front right element and oven were left on for several minutes, in order to ascertain if the "stove guard" would act as a safety device. The front right element became red hot and the oven continued to heat up. It was concluded that the "stove guard" was not operating as a safety device, and the element and oven were turned off. Inspector #547 left the area and Inspector #133 stayed in the Country Kitchen to ensure that no resident would have access to the hot stove surface or oven. Approximately 15 minutes later, the stove top was still very hot to the touch, and Inspector #133 left only after a housekeeper came along and indicated she would be cleaning the room. The housekeeper indicated she would stay until the element and oven had cooled down. It is noted that the door leading into the Country Kitchen is kept open, and is therefore resident accessible at all times.

On January 28, 2015 Inspector #133 spoke with the home's Facility Supervisor (FS) about the safety concerns presented by the stove in the Country Kitchen. The FS indicated that he had put the "stove guard" in place several years ago, and could not recall exactly what it offered. He did explain that stove guard is equipped with a motion sensor, and if the elements or oven are turned on, power will be cut off after 15 minutes if no motion has been detected. Following the conversation, the FS reacquainted himself with the device and demonstrated to Inspector #133 that the "stove guard" is in place to control the power to the stove, if used properly. A stove user should first have to activate power to the stove by pressing a specific button, and then once done, should deactivate the power to the stove by pressing another button, on the "stove guard". The FS indicated he would work with staff from the Activity department on creating some form of instructions that could be posted on the wall, to ensure that all users know how to activate and deactivate the power to the stove. On February 3, 2015 Inspector #133 observed that the instructions had been posted, and power to the stove was disabled at the time of observation.

As noted in Written Notification #10 within this inspection report, Inspector #133 found

that hazardous substances were not kept inaccessible to residents at all times. Hazardous cleaning products were found in unlocked cupboards in the Goulborne Village (GV), Nepean Village (NV) and West Carleton Village (WCV) serveries on January 27th and 28th, 2015. As well, on February 3 and 4, 2015 Inspector #133 found hazardous cleaning products in the main dish room, which was not locked when not being supervised by staff. Examples of the hazardous cleaning products found in the unit serveries and in the dish room, which have a Workplace Hazard Materials Information System (WHMIS) classification of "toxic" or "corrosive", are as follows: Ecolab – "Oasis 137 Orange Force" all purpose cleaner , "Ecoshine" metal polish, "Lemon Lift" surface cleaner with bleach, "Clinging Lime-A-Way" lime scale remover, "High Temp" grill cleaner, "CPS 490"; Wood Wyant – "Total" cleaner and polish. [s. 5.]

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 the home is a safe and secure environment for its residents, specifically related to the Douwe Egberts hot liquid dispenser in all unit serveries, the stove in the Country Kitchen, and hazardous substances in unit serveries and in the main dish room, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The Licensee has failed to comply with O. Reg. 79/10, s. 91. in that the licensee has failed to ensure that all hazardous substances at the home are kept inaccessible to residents at all times.

On January 27, 2015 Inspector #133 went into the Goulborne Village unit dining room servery and noted that the door to the cupboard under the sink was not fully closed, and that there was a key in the lock on the door. The Inspector observed the following hazardous substances stored within the cupboard: Ecolab Oasis 137 Orange Force, Wood Wyant Total Cleaner and Polish, and, EcoLab Ecoshine Metal Polish. As per the label on the bottles and the product Material Safety Data Sheets (MSDS), provided to Inspector #133 on January 28, 2015, by the home's Food Services Supervisor (FSS), these cleaning products are considered hazardous as they are classified as toxic. Although in diluted form, the Ecolab Oasis 137 Orange Force remains a toxic substance. At 10:25 am on January 27, 2015, Inspector #133 noted that there was a resident seated at the table closest to the servery, and there was no staff present and supervising the chemical storage cupboard.

On January 27, 2015 at 11:16 am, Inspector #133 entered the West Carleton Village unit dining room servery. There was a resident seated at one of the tables and no staff present supervising the area. The Inspector noted that the storage cupboard beneath the sink was closed, but not locked, and it contained the following hazardous substance: Ecolab Lemon Lift. As per the label on the bottle and the product MSDS, provided to Inspector #133 on January 28, 2015 by the home's FSS, this cleaning product is considered hazardous as it is classified as toxic.

On January 27, 2015 at 11:47am, Inspector #133 entered the Nepean Village unit dining room servery. There were 6 residents seated at tables and no staff present supervising the area. The Inspector noted that the storage cupboard beneath the sink was closed, but not locked, and it contained the following hazardous substances: Ecolab Ecoshine and Ecolab Clinging Lime-A-Way. As previously noted, the Ecoshine is classified as a toxic product. As per the label on the bottle of Lime-A-Way and the product MSDS, provided to Inspector #133 on January 28, 2015 by the home's FSS, this cleaning product is considered hazardous as it is classified as corrosive.

On January 28, 2015 while discussing the MSDS for the hazardous products, the home's FSS explained to Inspector #133 that in the Goulborne Village unit, the cleaning product cupboard under the sink should be closed and locked when staff are not present in the servery. The FSS went on to explain that in the Nepean Village (NV) and West Carleton Village (WCV) unit serveries, the cupboard beneath the sink has never been locked.

On February 4, 2015 the Manager of Hospitality Services (MHS)informed Inspector

#133 that locks were installed on the cupboard beneath the sink in the NV and WCV unit serveries, and that all dietary staff had been instructed to ensure that all cleaning products are stored securely. The MHS indicated that this had been done on January 28, 2015, after Inspector #133 had spoken with the FSS.

On February 3, 2015 at 11:14am, Inspector #133 found the door leading into the main dish room was not closed, and at 4:30pm, Inspector #133 found that the door leading into the main dish room was closed but not locked. There are no barriers in place that would prevent residents from reaching this dish room area. On both occasions, there were no staff present supervising the area. The dish room is connected to the main kitchen. On both occasions, the Inspector could hear someone within the main kitchen, but did not see them, nor did they see the Inspector. Inspector #133 found bottles and jugs of the following hazardous substances stored in the back corner of the dish room: EcoLab – High Temp Grill Cleaner, Lime-A-Way, CPS 490, Lemon Lift, Ecoshine ,Solid Super Impact and Wood Wyant Total universal cleaner and polish. These cleaning products are considered hazardous as they are classified as either toxic or corrosive. Inspector #133 discussed this situation with the home's Manager of Hospitality Services, who stated that staff had been directed to keep the door closed and locked when they leave the room.

On February 4, 2015 at 3:02pm, Inspector #133 found that the door leading into the main dish room was closed but not locked. There were no staff present supervising the area. All hazardous cleaning products previously noted remained in place. The Inspector stayed in the room for 3 minutes, and then left the area to find the MHS. The MHS followed up with staff, and later informed the Inspector that the door to the dish room would now be kept closed and locked at all times, and dietary staff would be expected to access the dish room via the kitchen. The MHS indicated their intention to have this door secured with card reader access. [s. 91.]

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 hazardous substances at the home be kept inaccessible to residents at all times, specifically related to hazardous substances stored in unit serveries and in the dish room, to be implemented voluntarily.

WN #12: 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 as part of the laundry services under clause 15 (1)(b) of the Act, every licensee of a long-term care home shall ensure that, policies and procedures are developed and implemented to ensure that there is a process to report and locate residents' lost clothing and personal items.

On January 28, 2015 Inspector #556 conducted an interview with Resident #31's family member who reported that the resident lost a winter coat in October, 2014 which was reported to RN Staff #107, and this item has not been found to this date.

On February 4, 2015 Inspector #547 interviewed RN Staff #107 who indicated that she could not recall this lost item for this resident, and that it is possible that Resident #31's family member may have reported this to her last Fall 2014. RN Staff #107 indicated that she should have completed a Lost Article Report for this item if it was reported to her, but she may have forgotten. RN Staff #107 could not confirm if any investigation to this missing winter coat had taken place.

Record review of the home's policy and procedure #460-12 titled Reporting Lost/Misplaced Clothing Items last reviewed July 2012 provided by the Manager of Hospitality Services procedure states: #2. Registered Nurse shall verify that the item is lost or misplaced by taking appropriate action, e.g. make thorough search, check with other departments and resident's family and complete a Lost Article Report.

RN Staff #107 or the Manager of Hospitality Services could not provide a Lost Article Report or any investigation documents of Resident #31's lost winter coat, which remains missing to this date. [s. 8. (1) (b)]

Issued on this 7 day of April 2015 (A1)(Appeal/Dir# Appeal/Dir#: DR #41)

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

Ministère de la Santé et 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

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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, L1K-0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, L1K-0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : JESSICA LAPENSEE (133) - (A1)(Appeal/Dir# Appeal/Dir#: DR #41)

Inspection No. / No de l'inspection : 2015_330573_0005 (A1)(Appeal/Dir# Appeal/Dir#: DR #41)

Appeal/Dir# / Appel/Dir#: Appeal/Dir#: DR #41 (A1)

Log No. / Registre no. : O-001472-15 (A1)(Appeal/Dir# Appeal/Dir#: DR #41)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Apr 07, 2015;(A1)(Appeal/Dir# Appeal/Dir#: DR #41)

Licensee / Titulaire de permis : CITY OF OTTAWA
Long Term Care Branch, 275 Perrier Avenue,
OTTAWA, ON, K1L-5C6

LTC Home / Foyer de SLD : CARLETON LODGE
55 LODGE ROAD, R. R. #2, NEPEAN, ON,
K2C-3H1

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : RICHARD GOURLIE

To CITY OF OTTAWA, 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 :

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 :

(A1)(Appeal/Dir# Appeal/Dir#: DR #41)
In order to achieve compliance with O. Reg. 79 10, s. 9 (1) 1. iii. and O. Reg. 79 10, s. 9 (2), the licensee will ensure that:

1. All resident accessible doors that lead to stairways, and all resident accessible doors that lead to the outside of the home, other than doors leading to secure outside areas that preclude exit by a resident, are

equipped with an audible door alarm that allows calls to be cancelled only at the point of activation. Specifically, staff within the City of Ottawa Corporate Security Operations Centre, or any other off-site location, must not have the ability to cancel a sounding alarm at any of the home's applicable doors. The licensee must prepare documented proof of such and must have this available at the home, for review upon the follow up inspection. Signatories to this document must include the person(s) with ultimate authority for the Corporate Security Operations Centre, as well as any other site from which the home's door alarms can be cancelled. The licensee must ensure that specific details as to how the ability to cancel alarms remotely using the Kantech security software, and any other applicable software, has been disabled, is included in the required documentation.

2. All of the pagers carried by registered nursing staff clearly indicate the location of an alarming door. The licensee will test every pager, at every applicable door, in order to accomplish this. This testing process must be documented and kept available at the home for review upon the follow up inspection.

3. All doors that lead to non-residential areas are kept closed and locked when the doors are not being immediately supervised by staff , in order to restrict resident access to these areas. This includes, but is not limited to, doors found to be in issue during the inspection. Specifically, the door leading to the main floor dish room door, as well as the door leading to the Laundry Room and the door leading to the Laundry Chute Room on the Nepean Village unit.

4. All staff complete a mandatory re - education on the need to ensure that all doors leading to non-residential area are kept closed and locked when they are not supervised directly by staffs and this training to be documented.

5. A plan is developed and implemented to ensure resident safety until such time as compliance with O. Reg. 79 10, s. 9 (1) 1. iii and O. Reg. 79 10, s. 9 (1) 2. are achieved.

TAKE NOTE: THIS ORDER HAS BEEN ALTERED TO REFLECT A DECISION OF THE DIRECTOR ON A REVIEW OF THE INSPECTOR S ORDER. THE DIRECTOR REVIEW WAS COMPLETED ON APRIL 1, 2015.

THE COMPLIANCE DATE HAS BEEN EXTENDED TO JUNE 8, 2015.

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg. 79/10, s. 9 (1) 1. iii. in that the licensee has failed to ensure that all resident accessible doors leading to stairways, and all resident accessible doors leading to the outside of the home, other than doors leading to secure outside areas that preclude exit by a resident, are equipped with an audible alarm that allows calls to be cancelled only at point of activation and is connected to the resident-staff communication and response system, or, 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.

At Carleton Lodge, at the main exit/entrance, there is a single inner door and a set of outer sliding doors. The single inner door is kept closed and locked as is required. The door can be unlocked by use of a swipe card, at the card reader on the wall next to the door. In order to ascertain if the inner door was equipped with an audible alarm as required, on January 27, 2015 beginning at 10:33am, Inspector #133 held the inner exit door open for several minutes. No alarm sounded. The home's Program Administration Clerk (PAC) Staff #122 approached the Inspector and explained that the door is not equipped with an audible alarm. The PAC explained that when any door that is secured with a card reader system such as the inner exit door, is open for a certain period of time, an alert will be triggered at the City of Ottawa Corporate Security Operations Centre (CSOC). The CSOC is off site, located within the City of Ottawa building at 101 Centre Point Drive. The PAC explained that when CSOC staff are alerted to a door that has been opened for too long, they are supposed to call the home and notify them. CSOC staff have the ability to cancel the alert and are supposed to do so only after receiving confirmation from the home that the door has been checked. The PAC explained that it is the same set up for all of the home's stairway doors and exit doors.

On January 28, 2015 Inspector #133 spoke with the home's Administrator about the requirement to have applicable doors equipped with an audible alarm as prescribed by O. Reg. 79/10, s. 9 (1) 1. iii. The Administrator informed that on February 2, 2015 the new audible alarm system and set up would "go live". He explained that they were presently working on information and education for all staff about the new set up and how to cancel a sounding alarm. He explained that the audible alarms would be connected to the resident-staff communication and response system. He

explained that within the home, it was expected that the alarms could only be cancelled at the alarming door. Inspector #133 had prior knowledge that CSOC staff have the ability to cancel an audible alarm sounding within the home, as a result of an inspection conducted in another one of the licensee's home on January 14 and 15, 2015 (Inspection # 2015_346133_0001). Inspector #133 informed the Administrator of this and he indicated that he had not been aware of this issue.

Applicable doors must be equipped with an audible alarm that allows calls to be cancelled ONLY at the point of activation. The point of activation is the door.

On February 3, 2015, at the main reception area, Inspector #133 held the inner exit door open and caused the audible alarm to sound. The door was closed and the alarm continued to sound, as required. Inspector #133 had asked the PAC to contact the CSOC and to explain to them that the Inspector would like them to demonstrate their ability to cancel a sounding alarm remotely. The PAC reached an alarm technician (AT) Staff #131 and he cancelled the sounding alarm when requested to do so. Inspector #133 then spoke with the AT on the phone and asked him to describe how he was able to cancel the alarm. The AT explained that he went into the alarm program, known as Kanetech, on his console, then into the alarm relay section. The AT explained he then highlighted the area related to the sounding alarm and cancelled it.

On February 3, 2015 at approximately 12:04pm, Inspector #133 went into West Carleton Village, down the Kinburn hallway and held the stairway door open in order to activate the audible alarm. The alarm sounded, the door was closed and the alarm continued to sound as is required. Inspector #133 used the RPN Staff #105 ID badge to cancel the alarm. The door alarms have been set up to be connected to the resident-staff communication and response system, and the location of an alarming door should be displayed on the registered nurses' pagers. The RPN indicated to the Inspector that her pager had not received an alert to the alarm. The RN Staff #101, was also in the area and informed that their pager had not received an alert to the alarm.

Inspector #133 spoke with the Administrator about this and he acknowledged that the new alarm system is still very much a work in progress.

On February 5, 2015 beginning at 10:52am, Inspector #133, in the company of a RPN Staff #138, tested the alarm at the stairway next to the main reception desk.

The RPN was in possession of pager #RN120 and #RN119. Another RPN, Staff #100, came along while this test was occurring. They were in possession of pager #RN112. While the alarm sounded after the door was held open, as required, the alert did not go through to two of the three pagers. Pager #RN120 and #RN119 did not receive an alert.

As previously noted, the licensee has chosen to connect the audible doors alarms to the resident-staff communication and response system (the system), and all registered staff pagers are to receive an alert to an alarming door. As per O. Reg. 79/10, s. 17 (1) f, the system must clearly indicate when activated where the signal is coming from.

This widespread non-compliance presents a potential risk to residents of the home.

(133)

2. The licensee has failed to comply with O. Reg. 79/10, s.9 (1) 2. in that the licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and that those doors are kept closed and locked when they are not being supervised by staff.

On January 26, 2015 Inspector #547 observed on the Nepean Village unit, that a Laundry room door was open and unsupervised by any staff member. PSW Staff #106 indicated that this door should have been closed as it is kept locked with a swipe key so residents on the unit do not enter. Inside this laundry room, were tide pods, and liquid purex detergent and a spray bottle with clear fluid inside which indicated bleach written on the bottle with black marker located on a shelf accessible to anyone entering this space. This laundry room door handle was equipped with a locking mechanism and swipe key pad however the door remained open to the main hallway to Nepean Village unit. No audible alarms related to this door were noted.

On February 3, 2015 on the Nepean Village unit, Inspector #547 noted at 11:00, that the door to the room with the laundry chute on this unit was left open which is located on the second floor of the home. This door was equipped with a locking mechanism however the door was not completely closed and could be pushed open. Inside this room, the laundry chute door was also unlocked and open with a chute size of 17.5 inches by 18 inches leading to the laundry room in the basement. Inspector #547 then interviewed PSW Staff #106 who indicated that staffs are expected to close this door when they are finished in this space, due to the risk inside this room with the laundry chute that does not lock.On this same date, Inspector #547 interviewed the Facility Supervisor who reported that all the laundry chute rooms should always be closed and locked when unsupervised. Upon observation of the chute itself, there was a key to actually keep this door locked, however the locking mechanism was no longer functional. The Facility Supervisor indicated that the home's expectation is to keep the main door to the Laundry chute room closed and locked at all times, preventing any resident access to this non-residential area.
(547)

3. This is specifically related to the door leading into the dish room, which is equipped with a lock, but was not kept closed and locked when not being supervised by staff.

On February 3, 2015 at 11:14am, Inspector #133 observed that the door leading into the main dish room was wide open. There are no barriers in place that would prevent residents from reaching this dish room area. There were no staff present supervising the area. The Inspector could hear someone talking on the phone in the main kitchen, but did not see them, nor did they see the Inspector. The dish room is connected to the main kitchen. In the immediate entrance of the dish room there is a service elevator, which allows unrestricted access to the basement level and into the 2nd floor servery. A variety of cleaning chemicals were observed to be stored in the back corner of the room, past the cart washing area. A few minutes later, the Manager of Hospitality Services (MHS) walked by the room. Inspector #133 stopped the MHS and discussion ensued about the safety risk presented by this situation. The MHS told the Inspector that staff had been directed to close and lock the door when they left the room.

On February 3, 2015 at 4:30pm, Inspector #133 returned to the dish room to further observe the cleaning products stored in the back corner of the room. The door was closed, but not locked. There were no staff present supervising the area. The Inspector could hear people in the main kitchen, but did not see them, nor did they see the Inspector. The Inspector took note of a variety of hazardous cleaning products (classified as toxic or corrosive) on the shelves: EcoLab – High Temp Grill Cleaner, Lime-A-Way, CPS 490, Lemon Lift, Eco Shine, and Wood Wyant Total universal cleaner and polish. A few minutes later, the dish room attendant, Staff #132, came into the dish room, from the kitchen. They explained that they go back and forth between the kitchen and the dish room during their shift. It was noted that there is no lock on the inside of the door that would allow the attendant to secure the area when they leave and go into the kitchen.

On February 4, 2015 at 3:02 pm, Inspector #133 returned to the dish room and found the door was closed but not locked. There were no staff present supervising the area. The Inspector stayed for 3 minutes and then left to find the Manager of Hospitality Services (MHS). The MHS followed up with the FSS and kitchen staff, and informed the Inspector that the door to the dish room would now be kept closed and locked at all times. The MHS qualified that staff would be allowed to open the door, if it got too hot in the room, as long as they remained in the room. Otherwise, staff would be expected to go through the kitchen to access the dish room. The MHS explained that they would move to securing this door with card reader access, as opposed to the key lock, that quotes were needed and that they anticipated this

could be done in about a month.

(133)

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

Jun 08, 2015(A1) (Appeal/Dir#: Appeal/Dir#: DR #41)

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

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

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
Toronto ON M5S 2B1
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
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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 7 day of April 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JESSICA LAPENSEE - (A1)(Appeal/Dir# Appeal/Dir#: DR #41)

Service Area Office /
Bureau régional de services : Ottawa