Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 31, 2015	2015_289550_0017	O-002528-15	Complaint

Licensee/Titulaire de permis

GENESIS GARDENS INC
438 PRESLAND ROAD OTTAWA ON K1K 2B5

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

FOYER ST-VIATEUR NURSING HOME
1003 Limoges Road South Limoges ON K0A 2M0

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

JOANNE HENRIE (550)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 31, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Activity Coordinator, several Personal Support Workers and several Residents.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Safe and Secure Home

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

- **2 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written hot weather related illness prevention and management plan that meets the needs of the residents:

* is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and
* is implemented when required to address the adverse effects on residents related to heat

A critical incident report was submitted to the Director on July 30th,2015 indicating that on July 28th, 2015 at 3:40pm the fire alarm was activated due to hot/humid weather. Residents were evacuated to the adjacent retirement home for approximately one hour while a venting system was placed in the attic to cool the air temperature. In order to cool the attic, the attic access traps had to be kept open until July 31st, 2015 which caused the temperature in the home to rise.

On July 31st, 2015 during an interview, the Director of Care and the Administrator indicated to Inspector #550 that they do not keep a log of the ambient temperatures in the home. They monitor by visually verifying the temperature that is displayed on the thermostat located at the end of the three hallways, the center core of the home and the dining room. The temperature is not monitored in the residents room.

Inspector #550 reviewed the home's policy titled "Guidelines for the prevention and management of hot weather" with a revision date of August 01, 2013. It was noted that the home's policy does not included all the revisions made to the "Guidelines for the Prevention and Management of Hot Weather Related Illness in Long Term Care Homes" document, revised July 2012 by the Ministry.

During an interview, the Administrator indicated the home's policy was revised in August 2013 by the previous administrator but it was not revised with the new guidelines of 2012. [s. 20. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is immediately, in as much detail as is possible in the circumstances, of each of the following incidents in the home:
1. An emergency, including fire, unplanned evacuation or intake of evacuees.
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

On July 28th, 2015 at 3:40pm the fire alarm in the attic was triggered due to extremely hot weather and the home had to evacuate the residents. A Critical Incident was submitted to the Director on July 30th, 2015 at 3:30pm; 2 days after the incident occurred.

On July 31st, 2015 Inspector #550 observed an outbreak sign at the front entrance of the home.

During an interview, the Director of Care indicated to Inspector #550 she did not immediately inform the Director of the unplanned evacuation of residents because she did not have time to do this until July 30th, 2015. She further indicated the home was experiencing a respiratory outbreak since July 30th, 2015 but she did not have the time to report the occurrence to the Director also. [s. 107. (1)]

Issued on this 28th day of August, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JOANNE HENRIE (550)
Inspection No. / No de l'inspection :	2015_289550_0017
Log No. / Registre no:	O-002528-15
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 31, 2015
Licensee / Titulaire de permis :	GENESIS GARDENS INC 438 PRESLAND ROAD, OTTAWA, ON, K1K-2B5
LTC Home / Foyer de SLD :	FOYER ST-VIATEUR NURSING HOME 1003 Limoges Road South, Limoges, ON, K0A-2M0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	

To GENESIS GARDENS INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

Order / Ordre :

The licensee shall:

- review their policy titled "Guidelines for the prevention and management of hot weather" to reflect the "Guidelines for the Prevention and Management of Hot Weather Related Illness in Long Term Care Homes" document, revised July 2012,
-ensure that all staff receive education on the revised policy and,
-that the policy is implemented.

This order is to be implemented immediately and complied by August 7, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that the written hot weather related illness prevention and management plan that meets the needs of the residents:

* is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and
* is implemented when required to address the adverse effects on residents related to heat

A critical incident report was submitted to the Director on July 30th,2015 indicating that on July 28th, 2015 at 3:40pm the fire alarm was activated due to hot/humid weather. Residents were evacuated to the adjacent retirement home for approximately one hour while a venting system was placed in the attic to cool the air temperature. In order to cool the attic, the attic access traps had to be kept open until July 31st, 2015 which caused the temperature in the home to rise.

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Inspector #550 reviewed the home's policy titled "Guidelines for the prevention and management of hot weather" with a revision date of August 01, 2013. It was noted that the home's policy does not included all the revisions made to the "Guidelines for the Prevention and Management of Hot Weather Related Illness in Long Term Care Homes" document, revised July 2012 by the Ministry.

During an interview, the Administrator indicated the home's policy was revised in August 2013 by the previous administrator but it was not revised with the new guidelines of 2012. (550)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 07, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Issued on this 31st day of July, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Joanne Henrie

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