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**

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## Amended Public Copy/Copie modifiée du public de permis

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log #/ Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Mar 09, 2015; | 2015_289550_0004 (A1) | O-001548-15 | Resident Quality Inspection |

### Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST UNIT 12 PETERBOROUGH ON K9K 2M9

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

GARDEN TERRACE
100 Aird Place KANATA ON K2L 4H8

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

JOANNE HENRIE (550) - (A1)

## Amended Inspection Summary/Résumé de l'inspection modifié

**Please note WN #12 has been rescinded.**

**Issued on this 9 day of March 2015 (A1)**

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

**Original report signed by the inspector.**

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

JOANNE HENRIE (550) - (A1)

## 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): February 17, 18, 19, 20, 23, 24, 25, 26 and 27 2015**

**Critical Incident Reports #2882-000025-14, #2882-000027-14, #2882-000032-14 and #2882-000032-14 were also inspected during this inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Clinical Coordinator, the RAI Coordinator, the Life Enrichment Coordinator, the Nutritional Care Manager, the Assistant Nutritional Care Manager, the Environmental Maintenance Services Manager, a Physiotherapist, several Registered staff members, several Personal Support Workers, several Nutritional Aids, several residents and several family members. The inspector(s) also reviewed several policies and procedures, several resident health records and minutes of the Resident Council.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**

**Accommodation Services - Laundry**

**Accommodation Services - Maintenance**

**Continence Care and Bowel Management**

**Dignity, Choice and Privacy**

**Dining Observation**

**Family Council**

**Infection Prevention and Control**

**Medication**

**Minimizing of Restraining**

**Nutrition and Hydration**

**Personal Support Services**

**Prevention of Abuse, Neglect and Retaliation**

**Residents' Council**

**Responsive Behaviours**

**Safe and Secure Home**

**Skin and Wound Care**

**Snack Observation**

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

**12 WN(s)**
**7 VPC(s)**
**2 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home**

**Specifically failed to comply with the following:**

**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:**
**1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,**
**i. kept closed and locked,**
**ii.equipped with a door access control system that is kept on at all times, and**
**iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,**
**A. is connected to the resident-staff communication and response system, or**
**B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Reg. 79/10, s. 9 (1) 1. i. in that the licensee has failed to ensure that all doors leading to the outside of the home are kept locked. This is specifically related to the home's main exit door.

On February 17th, 2015, it was observed by Inspector #599 that the home's main exit

consists of two sets of sliding doors, with a small vestibule area in-between. To leave the home, a code is entered on the key pad on the wall to the right of the inner door. This serves to activate the motion sensor, and the door slides open automatically. Once in the vestibule, the motion sensor on the outer door causes it to slide open. An access code is not required for the outer door.

On February 20th, 2015, through observation and discussion with the home's Environment Services Maintenance Manager and Director of Care, it was determined that neither door is kept locked at all times. Both the inner and outer doors are equipped with a thumb bolt lock. The Environmental Services Maintenance Manager explained to Inspector #599 that nursing staff lock the inner door during the night shift, by engaging the thumb bolt lock, to prevent unauthorized entry into the home. The door is unlocked again in the morning to allow for access into the home. There is no other form of lock on the inner or outer door. The coded key pad is only connected to the motion sensor, not to a locking device. When the thumb bolt lock is not applied, the sliding door can be manually slid open, with little effort. This was demonstrated by Inspector #599, in the presence of, the home's Environmental Services Maintenance Manager, and the home's Director of Care.

Further exacerbating the risk posed by the unlocked door is the fact that neither exit door is equipped with an alarm as is required by O. Reg. 79/10, s. 9 (1) 1. iii. The inner or outer sliding door must be kept closed and locked at all times, and that same door must be alarmed as prescribed.

This widespread non-compliance presents a risk to the safety of the home's residents. It is noted that on February 20th, 2015, the home's Director of Care approached Inspector #599 and indicated that in the afternoon of February 20th, 2015, a door technician had been called for installing a locking mechanism to the main front exit door. [s. 9. (1)]

2. 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 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 canceled only at the 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. This is related to all resident accessible stairway doors and exit doors within the home.

On February 20th, 2015, Inspector #599 toured the home with the Environmental Services Maintenance Manager in order to assess and discuss door security. The Environmental Services Maintenance Manager tested the doors alarm in the presence of inspector #599 and it was observed that none of the home's resident accessible doors that lead to stairways, or that lead to the outside of the home, were equipped with an alarm as is prescribed by O. Reg. 79/10, s. 9 (1) iii.

At the time of the inspection, applicable doors included: the front exit door, the 5 resident accessible doors leading to stairway BG, the 5 resident accessible doors leading to stairway AG, beyond stairway AG, there is an exit door leading to the front of the building and beyond stairway BG there is an exit door leading to the back parking lot towards the Queensway. [s. 9. (1) 1. iii.]

***Additional Required Actions:***

**CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

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**WN #2: 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 failed to comply with O. Reg. 79/10 s.8 (1)(b) 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 to be complied with, in that the home failed to ensure compliance with the following policy.

As per O.Reg79/10, s.110(7) The licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

5. The person who applied the device and the time of application

6. All assessment, reassessment and monitoring, including the resident's response.

7. Every release of the device and all repositioning.

On February 25, 2015, the home's policy on Minimizing of Restraints was provided to Inspector #161 by the Director of Care (DOC). Upon review of the policy it is noted that there is a document titled: Restraint/PASD Monitoring Form" that must be completed when a personal assistance service device (PASD) or a physical restraint is used. The forms' purpose, confirmed by the DOC, is for the monitoring of the Resident when a physical device is applied. The form clearly details the description of the monitoring to include: who applied the device, when the physical device is released and when the resident is repositioned. It is noted that the form clearly indicates that these tasks are to be completed on an hourly basis.

On February 24, 2015 the Restraint/PASD Monitoring Forms of Resident's #032, #33, #34, #35, #36 who reside on the second floor home area were reviewed by Inspector #161 and Inspector #550 at 1:45 p.m. All 5 Resident's Restraint/PASD Monitoring forms had been prematurely completed for 2:00 p.m. and 3:00 p.m., respectively.

On February 24, 2015 the Restraint/PASD Monitoring Forms of Resident's #004, #037, #038, #039, #040, #041, #042, #043 who reside on the first floor home area were reviewed by Inspector #161 and Inspector #599 at 2:00 p.m. All 8 Resident's Restraint/PASD Monitoring forms had been prematurely completed for 3:00 p.m.

On February 26, 2015 the Restraint/PASD Monitoring Forms of Resident's #044, #045, #046, #47, #48, #49 and #50 who reside on the fifth floor home area were

reviewed by Inspector #161 and Inspector #559 at 1:45 p.m. All 5 Resident's Restraint/PASD Monitoring forms had been prematurely completed for 2:00 p.m. and 3:00 p.m. respectively.

As per O. Reg 79/10, s. 68 (2) (a) the licensee shall ensure that the nutrition care and hydration programs include the development and implementation of policies and procedures relating to nutrition care and dietary services and hydration.

On February 26, 2015, the Food and Fluid Intake policy (NC-1.8) was photocopied from the Food and Fluid Intake Monitoring binder on the second floor of the home. According to the policy snack (nourishments) shall be recorded by entering a check mark in the box indicating that they have been provided to the resident.

On February 23, 2015, Inspector #551 observed the afternoon nourishment pass on the third floor which is at 1400. Five residents (# 27, #28, #29, # 17 and #30) were observed to be in the tv lounge or in the adjacent area on the east side of the unit.

At 13:55, it was noted by Inspector #551 that the Food and Fluid Monitoring for the afternoon snack had been filled out for # 27, #28, #29, # 17 and #30 before the nourishment pass had started. Specifically it was recorded that Resident #17 had refused a snack and beverage, that Resident #29 had consumed a snack, but the beverage box was blank, that Resident # 27 had consumed a snack and beverage and that Residents# 28 and #30 had consumed a snack but refused a beverage.

Observation of the nourishment pass revealed that Resident #017 refused a snack, Resident # 30 was fed a snack but no beverage and Residents # 27, #28 and #29 were not offered a snack or beverage. [s. 8. (1) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that observations and care are documented at the time the care was provided, to be implemented voluntarily.***

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**WN #3: 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 has failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

On February 18, 2015 the following was observed:
Inspector #599 observed Resident #007's wheelchair's cushion dirty with white stain
Inspector #599 observed Resident #011's wheelchair frame dirty with dried food.
Inspector #551 observed Resident #014's wheelchair seat cover dirty with a white matter.

On February 23, 2015 Inspector #550 and the Director of Care observed the following:
Resident #007's wheelchair frame was visibly soiled with dried food and the cushion was visibly soiled with splatters of dried liquid.
Resident #011's wheelchair frame, cushion and back rest was visibly soiled with dried food.
Resident #14's wheelchair seat cover is soiled with white crusty matter.

RPN staff #S101 indicated to Inspector #550 that it is the responsibility of the night PSW's to clean the resident's wheelchairs and walkers as per the established schedule. He/she showed and provided the schedule and sign off sheet for the cleaning of the walkers and wheelchairs. Inspector #550 observed the "night shift cleaning duties" from February 1 to 22, 2015 and it indicated the following:

Resident #007's wheelchair was scheduled to be cleaned on February 2, 9, and 16. It was documented on the sign off sheet it was cleaned on February 2nd.
Resident #011's wheelchair was scheduled to be cleaned on February 5, 12, and 19. It was documented on the sign off sheet it was cleaned on February 12.
Resident #014's wheelchair was scheduled to be cleaned on February 1, 8, 15 and 22. It was documented on the sign off sheet it was cleaned on February 1 and 8.

During an interview, the Director of Care indicated to Inspector #550 the night PSW's are responsible for cleaning the resident's wheelchair and walker as per the established schedule for the month. She indicated they are to document this on the sign off sheet once it is done. If the wheelchair or the walker of a resident gets dirty because a resident spills something on it, it is the home's expectation that all PSW's will clean the spill on a daily basis. [s. 15. (2) (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 resident's personal wheelchairs are kept clean at all times, to be implemented voluntarily.***

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**WN #4: 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 has failed to comply with O.Reg 79/10 r.17 (1) (a) in that the licensee did not ensure that the home is equipped with a resident-staff communication and response system that can be easily used by residents, staff and visitors at all times.

For the purpose of this report, the resident-staff communication and response system is often referred to as the call bell system.

The home is equipped with a Vigil resident-staff communication and response system that clearly indicates when activated, where the signal is coming from. Residents activate this communication system by pulling on a call bell cord located in their room and in their bathroom.

On February 19, 2015 Inspector #550 observed in room 323-A the call bell cord wrapped around the side rail which was lowered and covered by the bedspread. When Inspector #550 asked Resident #051 if he/she could access the call bell, the resident replied that he/she was unable to locate the call bell.

On February 24, 2015 Inspector #599 observed Resident #012 did not have a pull cord call bell in the room or the washroom it was a push button; the call bell cord was missing from call bell console on the wall. Registered Staff #S101 was unaware of any reason why Resident #012 did not have pull cords in the room and the washroom.

During an interview, the Director of Care indicated she was not aware Resident #12 did not have call bell cords in the room and the bathroom. She indicated to Inspector #599 that management did not give any instruction to staff to remove the call bell cords from the room of Resident #012. [s. 17. (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 all call bells can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect**

**Specifically failed to comply with the following:**

**s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

1. The Licensee has failed to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A Critical Incident report was submitted to the Director on a specific day in November 2014 reporting an incident of neglect of Resident #017 by a staff member that had occurred on a specific day in November 2014.

The home's internal investigation of the incident indicated that on a specific day in November 2014 at 22:55pm, PSW staff #S125 noticed a strong odor of feces in the hallway near Resident #017 bedroom as he/she was arriving on the floor to start his/her shift. PSW entered Resident #017's room and observed Resident #017 had feces all over his/her hands and clothes. PSW staff #S125 informed evening PSW staff #S126 he needed to change Resident #017 as the resident had had a bowel movement. PSW staff #S126 indicated to PSW staff #S125 when he did his last round at 22:40pm Resident #017 was clean and sleeping and that he would not change Resident #017 as his shift was now over and left the unit. PSW staff #125 was upset from his comment and did not provide the care and assistance to Resident #017 immediately as needed; PSW #S125 waited until 23:40pm. By this time, Resident #017 had dried feces under his/her fingers and was observed by RN staff #124 with his/her fingers by his/her mouth.

Resident #017 was left in his/her feces 40 minutes before staff #S125 provided care to the resident knowing the resident had had a bowel movement and had feces on his/her hands and clothes.

During an interview, the Assistant Director of Care indicated to Inspector #550 the home's investigation revealed that PSW staff #S125 had neglected Resident #017 by not immediately providing care to this resident who had had a bowel movement and was left with feces all over his/her hands and clothes. She indicated staff #S125 was disciplined as a result of her actions. [s. 19. (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 residents with immediate needs receives the care and assistance required immediately, to be implemented voluntarily.***

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**WN #6: 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 ensure that each resident of the home had his or her personal items labeled within 48 hours of admission and of acquiring, in the case of new items.

On February 17, 2015, the following unlabeled personal care items were observed by Inspector #599:

On the counter in the shared tub room on the first floor home area: a hair comb with visible hair, a used jar of white petroleum jelly, a hair brush with visible hair left in the bath tub and two disposable razors with visible debris.

In the shared tub room on the third floor home area: two used razors with visible debris, an unlabeled care basket containing one used deodorant stick, two used bars of soap, one used jar of white petroleum jelly.

In the shared tub room on the fifth floor home area: an unlabeled care basket containing two used tubes of toothpaste and a used jar of white petroleum jelly.

During an interview on February 24 2015, the Director of Care (DOC) indicated to Inspector #599 that it was expected that all resident's personal items were labeled with the resident's name. [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 all resident have their personal items labeled within 48 hours of admission and when acquiring new items, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning**

**Specifically failed to comply with the following:**

**s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).**

**s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).**

**s. 71. (7) The licensee shall ensure that food and beverages that are appropriate for the residents' diets are accessible to staff and available to residents on a 24-hour basis. O. Reg. 79/10, s. 71 (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that each resident is offered a minimum of a between-meal beverage in the afternoon.

On February 18 and 19, 2015, respectively, Residents #052 and #051 indicated to Inspector #550 that they were not offered a beverage between meals and in the evening after dinner. On February 18, 2015, Resident #053 indicated to Inspector #551 that she was not offered a beverage in the evening.

The afternoon nourishment pass was observed on the third floor on February 23, 2015, and the evening nourishment pass was observed on the fifth floor on February 24, 2015.

The following observations are related to the afternoon nourishment pass on February 23, 2015:

Five residents were sitting in the tv lounge or adjacent area on the east side of the unit. Two residents (Resident # 017 and Resident #30) were observed to be sitting in front of the tv, and three residents (Resident #27, Resident #28 and Resident #29) were in an alcove looking out the window.

PSWs staff #S110 and staff #S113 were circulating the nourishment cart.

At 14:21, the PSWs entered the east side and asked Resident #017 if he/she would like a snack. PSW staff #S113 then sat to feed Resident #030 a snack from a bowl, but no beverage was offered. At this time, the nourishment cart, including all

beverages had been removed from the dining room.

Residents #30, #27, #28 and #29 were not offered a beverage.

The care plans for Residents #30, #27, #28 and #29 were reviewed, and there is no indication that they were not to be offered an afternoon beverage. [s. 71. (3) (b)]

2. The licensee has failed to ensure that each resident is offered a minimum of a snack in the afternoon.

During the Resident Interview portion of the Resident Quality Inspection (RQI), residents reported not being offered a snack in the afternoon or in the evening.

The afternoon nourishment pass was observed on the third floor on February 23, 2015.

Five residents were sitting in the tv lounge or adjacent area on the east side of the unit. Two residents(Resident #017 and Resident #30) were observed to be sitting in front of the tv, and three residents (Resident #27, Resident #28 and Resident #29) were in an alcove looking out the window.

PSWs, Staff Member #S110 and Staff Member #S113 were circulating the nourishment cart.

At 14:21, the PSWs entered the east side and asked Resident #017 if he/she would like a snack. PSW, Staff Member #113 then sat to feed Resident #030 a snack. At this time, the nourishment cart, including all snacks had been removed from the dining room.

Residents #27, #28 and #29 were not offered a snack.

On February 24, 2015 Inspector #551 discussed with PSW staff #S113 she observed on February 23, 2015 that PSW staff #S113 and PSW staff #S110 did not offer a snack or a beverage to Residents #027, #028 and #029 in the afternoon when distributing the collation to other residents. PSW staff #S113 indicated to Inspector #551 Resident #027 is now on a puree textured diet and usually refuses his/her afternoon snack and beverage, Resident #028 cannot answer and Resident #029 also usually refuses and is on a liquid puree diet. He/she indicated due to these resident's past history of refusal, they assumed that Residents #027, #028 and #029

did not want an afternoon snack or beverage therefore they did not offer it to them.

The care plans for Residents #27, #28 and #29 were reviewed, and there was no indication that they were not to be offered an afternoon snack. [s. 71. (3) (c)]

3. The licensee has failed to ensure that appropriate food and beverages for all residents' diets accessible to staff and available to residents on a 24-hour basis.

On February 17, 2015 Inspector #550 observed the refrigerator in each servery on the first floor's secured unit to be stocked with bread, milk, different kind of juices, butter and jam.

During an interview RPN staff #103 indicated to Inspector #550 staffs have access to juices, yogurt, and toast in the servery. She indicated for the residents who are on modified textured diets the nurses always have access to pudding or apple sauce that they can give to those residents. She indicated they do not have access to the kitchen outside of the regular hours of operation.

On February 20, 2015 during an interview, RPN staff #S105 indicated to Inspector #550 when a resident who has a modified textured diet is hungry or comes back from the hospital after the kitchen's regular hours of operation they would give this resident either Resource 2.0, pudding or apple sauce. She indicated she is unsure if they have access to the kitchen after the regular hours of operation.

During an interview on February 24, 2015 RPN staff #S112 indicated to Inspector #551 if a resident returns to the home outside of kitchen's regular hours of operation the evening staff do not have access to the kitchen. She indicated she thinks when supper is over, the nutrition aid portions the left overs, puts them in a baggies and leaves them in the servery's refrigerator. She indicated the nurse in charge used to have access to the kitchen but she does not think she still has.

The Nutrition Care Manager indicated to Inspector #550 the kitchen's regular hours of operation are from 5:30am to 8:00pm.  She indicated the refrigerators in each servery are stocked daily with ice cream, bread and yogourt. She indicated last week she started stocking plastic bins with ice cream, yogourt, apple sauce, cereals, instant oatmeal and sliced bread that will be distributed to each servery for staff to have access to if a resident is hungry and these bins should be available as of next week. She indicated the nurse in charge has the key to access the kitchen outside of kitchen's regular hours of operation where they have access to frozen muffins, cookies

and pureed entrees if needed. [s. 71. (7)]

***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 is offered a between meal beverage, a between meal snack in the afternoon and evening and that food for all diet types are available to residents on a 24h basis, to be implemented voluntarily.***

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device**

**Specifically failed to comply with the following:**

**s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:**
**1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).**

**Findings/Faits saillants :**

1. The licensee failed to comply with O. Reg 79/10 s. 110. (1) 1 in that the home did not apply a physical device in accordance with the manufacturer's instruction.

Resident #005 has resided at the home since 2012. He/she requires extensive assistance or is totally dependent for all aspects of care.

On February 23, 2015, Resident #005 was observed by Inspector #551 to be sitting in his/her wheelchair with a front closing lap belt applied. The wheel chair was in a tilt position, and the resident's feet were resting on foot rests. The front closing lap belt was observed to be loosely applied as there was a gap between the resident's body

and the lap belt. PSW staff #S108 examined the lap belt and indicated that it was too loose. She readjusted the front closing lap belt to fit the resident properly.

On February 24, 2015, Resident # 005 was observed by Inspector #551 to be sitting in his/her wheelchair with a front closing lap belt applied. The wheelchair was in a tilt position, and the resident's feet were resting on foot rests. The front closing lap belt was observed to be loose as evidenced by Inspector #551 being able to insert a closed fist between Resident #005's waist and the lap belt. PSW staff #S116 examined the belt, indicated that it was too loose and readjusted the front closing lap belt to fit the resident properly.

PSW staff #S113 and staff #S114 were interviewed and indicated that the lap belt should be tightened so that fingers only can be inserted between the resident and the lap belt.

The Director of Care provided a copy of the Owner's Operator and Maintenance Manual for Resident #005's lap belt which indicated that the pelvic belt should be worn low across the front of the pelvis within preferred angle zones and that the belt should be adjusted as firmly as possible, being mindful of the user's comfort. [s. 110. (1) 1.]

2. On February 23, 2015, Resident #017 was observed by Inspector #599 to be sitting in his/her wheelchair with a front closing lap belt. His/her feet were on the ground. The lap belt was resting on Resident #017's lap, almost to his/her knees, and there was greater than a six inch gap between the resident's waist and the lap belt. Inspector #599 asked the resident if he/she could release the lap belt, and he/she could not.

PSW staff #S110 attempted to tighten the belt and was unable to. She stated that this had been an on-going issue.

On February 24, 2015 at approximately 15:00, Resident #017 was observed to be sitting in his/her wheel chair with a front closing lap belt and his/her feet on the ground. The lap belt was resting on his/her lap with approximately a three inch gap between the resident's waist and the lap belt. PSW staff #S114 examined the lap belt, indicated that it was too loose and readjusted the front closing lap belt to fit the resident properly. PSW, staff #S114 indicated that the lap belt should be tightened so that fingers only can be inserted between the resident and the lap belt.

On February 24, 2014 at 18:30, Inspector #551 pulled on the plastic clip of Resident

#017's lap belt and was able to pull the lap belt away from the resident's body with no resistance. On February 25, 2015, PSW staff #S113 indicated to Inspector #551 that when the resident scratches his/her back or side, the lap belt buckle moves forward and loosens the lap belt. PSW staff #S113 was then able to tighten the lap belt so it would fit the resident properly.

On February 27, 2015, the Assistant Director of Care, the Clinical Care Coordinator and the Physiotherapist indicated the expectation regarding the application of a lap belt was that it should be to a tightness of two fingers between the belt and the resident's body. [s. 110. (1) 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 all physical devices are applied in accordance with the manufacturer's instruction, to be implemented voluntarily.***

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**WN #9: 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 has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director?
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

A Critical Incident report was submitted to the Director on a specific day in November 2014 reporting an incident of neglect to Resident #017 by a staff member that had occurred on a specific day in November 2014.

On a specific day in November 2014, RN staff #124 left a note under the Assistant Director of Care's office door reporting that a resident had been left with feces on his/her hands and nightgown for more than 30 minutes by a PSW.

The Assistant Director of Care indicated to Inspector #550 during an interview she received the report from staff #S124 informing her of an incident of neglect upon her return to work on Monday November 17, 2014 and she immediately started an investigation. The ADOC reported to Inspector #550 that during the investigation of the incident, RN staff #S124 indicated to her she did not know why she did not report the incident immediately to a supervisor instead of leaving a note under the Assistant Director of Care's office door, especially since this incident occurred during the weekend. She indicated all incidents of neglect have to be reported immediately to a supervisor so the supervisor can immediately notify the Director.

The Assistant Director of Care indicated to Inspector #550 the Administrator was supposed to have contacted the Director by telephone or e-mail on November 17, 2014 when they became aware of the incident of neglect but she does not have any documentation to support this. She indicated she did not know why the Home did not immediately report the incident to the Director.

The incident was reported to the Director 9 days after the Licensee was made aware of the incident. [s. 24. (1)]

**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident is dressed appropriately, suitable to the time of day and in accordance with their preferences, in their own clean clothing and appropriate clean footwear.

On February 18, 2015, Resident #008 was observed by Inspector #550 in the dining room sitting in his/her wheelchair at the dining room table. Inspector observed the resident's lower back and upper part of his/her buttocks were exposed between the seat and the back rest of the wheelchair; an open area of approximately 3 inches. Inspector observed Resident #008 was wearing a beige brief and the skin of his/her left buttock and left thigh was exposed.

On February 20th, 2015 Inspector #550 observed Resident #008 sitting in his/her wheelchair at the dining room table. Inspector observed the resident's pants were not covering his/her behind as Inspector was able to observe through the opening of the wheelchair between the seat and the back rest of the chair the resident was wearing a beige brief and his/her skin was exposed.

On February 20, 2015 during an interview, PSW staff #S106 who is the PSW assigned to care for Resident #008 indicated to Inspector #550 she was not aware the resident was dressed this way as she was not the one who put his/her pants on in the morning. PSW indicated to Inspector #550 Resident #008 only has three pairs of pants that fit him/her and that are in a good state of repair. PSW further indicated when a resident is in need of new clothes, she has to inform the resident's substitute decision maker of what is needed when they come to visit. She indicated she will inform the resident's daughter for the need for new pants the next time she comes to visit, but also indicated the resident's daughter does not come to visit often. At this time, PSW staff #S106 was able to pull the resident's pants from each side and fasten them so the resident's behind was covered.

RPN staff #S105 indicated to Inspector #550 whenever a resident needs new clothes,

PSWs are supposed to inform the registered staff and they will contact the resident's family.

During an interview the Director of Care indicated to Inspector #550 this kind of situation is not acceptable and staff are required to cover up the resident when the clothes are not fitting properly until new clothes are purchased. She indicated to Inspector #550 when a resident requires new clothes, the PSW's are expected to inform the registered staff who will call the the resident's substitute decision maker to inform them of the need for new clothes and not wait for family to visit. She indicated to Inspector #550 Resident #008's daughter does not visit often as she lives out of town. [s. 40.]

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

**Specifically failed to comply with the following:**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:**
**1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the daily and weekly menus communicated to residents.

On February 17, 2017 Inspector #550 observed the daily menu was not posted on the secured unit west wing dining room. Inspector observed on secured unit east wing dining room the menu posted for lunch was not what was being served. The lunch menu that was posted indicated:
-pulled pork on wheat bun,
-corn cobbette,
-chilled peache slices,
Alternate choice:
-macaroni and cheese,
-spinach salad,
-butterscotch pudding with whipped topping

The menu that was being served was:
-corn chowder,
-mushroom and three cheese quiche,
-Garden salad with dressing,
-stewed strawberries and rhubarb,
Alternate choice:
-Turkey burger on wheat bun
-creamy coleslaw
-Rainbow sherbet.

The Assistant Nutrition Care Manager changed the menu that was posted for breakfast, lunch and dinner for that day after Inspector #550 observed the right menu was not posted.

The Nutrition Care Manager indicated to Inspector #550 it is expected by the Home that the nutrition care aid who is working in the morning to post the daily menu on the board in each dining room on a daily basis. [s. 73. (1) 1.]

## (A1)
## The following Non-Compliance has been Revoked: WN #12

**WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance**

**Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,**

**(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;**

**(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;**

**(c) identifies measures and strategies to prevent abuse and neglect;**

**(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and**

**(e) identifies the training and retraining requirements for all staff, including,**

**(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and**

**(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.**

**Issued on this 9 day of March 2015 (A1)**

**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**

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## Amended Public Copy/Copie modifiée du public de permis

**Name of Inspector (ID #) / Nom de l'inspecteur (No) :** JOANNE HENRIE (550) - (A1)

**Inspection No. / No de l'inspection :** 2015_289550_0004 (A1)

**Appeal/Dir# / Appel/Dir#:**

**Log No. / Registre no. :** O-001548-15 (A1)

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

**Report Date(s) / Date(s) du Rapport :** Mar 09, 2015;(A1)

**Licensee / Titulaire de permis :** OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST, UNIT 12,
PETERBOROUGH, ON, K9K-2M9

**LTC Home / Foyer de SLD :** GARDEN TERRACE
100 Aird Place, KANATA, ON, K2L-4H8

Ontario

**Ministry of Health and Long-Term Care**

**Order(s) of the Inspector**

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

**Ministère de la Santé et des Soins de longue durée**

**Ordre(s) de l'inspecteur**

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

**Name of Administrator / Nom de l'administratrice ou de l'administrateur :** CAROLYN DELLA FORESTA

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To OMNI HEALTH CARE LIMITED PARTNERSHIP, you are hereby required to comply with the following order(s) by the date(s) set out below:

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**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

## 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

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 :**

## 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

In order to achieve compliance with O. Reg. 79/10, s. 9 (1) 1. i., the licensee shall ensure that all resident accessible doors leading to the outside of the home, and all resident accessible doors leading to the outside of the home, other than doors leading to secure outside areas that preclude exit by resident are kept closed and locked.

The specific focus of this Compliance Order is on the home's main front exit door, which is a sliding door.

The licensee must ensure that there is a locking mechanism in place on the door, that is engaged at all times, that renders it impossible to slide the door open.

The licensee will ensure that the door locking mechanism complies with any or all other applicable legislated requirements that may apply to this door, including, but not limited to, the Ontario Fire Code.

The licensee will implement measures to ensure the safety of all residents until such time as compliance is achieved with O. Reg. 79/10, s. 9 (1) 1. i.

**Grounds / Motifs :**

1. The licensee has failed to comply with O. Reg. 79/10, s. 9 (1) 1. i. in that the licensee has failed to ensure that all doors leading to the outside of the home are kept locked. This is specifically related to the home's main exit door.

On February 17th, 2015, it was observed by Inspector #599 that the home's main exit consists of two sets of sliding doors, with a small vestibule area in-between. To leave the home, a code is entered on the key pad on the wall to the right of the inner door. This serves to activate the motion sensor, and the door slides open automatically. Once in the vestibule, the motion sensor on the outer door causes it to slide open. An access code is not required for the outer door.

On February 20th, 2015, through observation and discussion with the home's Environment Services Maintenance Manager and Director of Care, it was determined that neither door is kept locked at all times. Both the inner and outer doors are equipped with a thumb bolt lock. The Environmental Services Maintenance Manager explained to Inspector #599 that nursing staff lock the inner door during the night shift, by engaging the thumb bolt lock, to prevent unauthorized entry into the home. The door is unlocked again in the morning to allow for access into the home. There is no other form of lock on the inner or outer door. The coded key pad is only connected to the motion sensor, not to a locking device. When the thumb bolt lock is not applied, the sliding door can be manually slid open, with little effort. This was demonstrated by Inspector #599, in the presence of, the home's Environmental Services Maintenance Manager, and the home's Director of Care.

Further exacerbating the risk posed by the unlocked door is the fact that neither exit door is equipped with an alarm as is required by O. Reg. 79/10, s. 9 (1) 1. iii. The inner or outer sliding door must be kept closed and locked at all times, and that same door must be alarmed as prescribed.

This widespread non-compliance presents a risk to the safety of the home's residents.
It is noted that on February 20th, 2015, the home's Director of Care approached Inspector #599 and indicated that in the afternoon of February 20th, 2015, a door technician had been called for installing a locking mechanism to the main front exit door. (550)

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

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

Apr 03, 2015

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**Order # /**
**Ordre no :** 002

**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 :**

## 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

In order to achieve compliance with O. Reg. 79/10, s. 9 (1) 1. iii, the licensee shall 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 door alarm that allows calls to be cancelled only at the point of activation. This audible door alarm must be connected to the resident-staff communication and response system, OR, be 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.

In addition as required by O. Reg. 79/10, s. 9 (1) 4. the licensee will ensure that all alarms for doors leading to the outside are connected to a back-up power supply.

The licensee will implement measures to ensure resident safety until such time as compliance is achieved with O. Reg. 79/10, s. 9 (1) 1. iii.

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

## Ordre(s) de l'inspecteur

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

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

**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 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 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. This is related to all resident accessible stairway doors and exit doors within the home.

On February 20th, 2015, Inspector #599 toured the home with the Environmental Services Maintenance Manager in order to assess and discuss door security. The Environmental Services Maintenance Manager tested the doors alarm in the presence of inspector #599 and it was observed that none of the home's resident accessible doors that lead to stairways, or that lead to the outside of the home, were equipped with an alarm as is prescribed by O. Reg. 79/10, s. 9 (1) iii.

At the time of the inspection, applicable doors included: the front exit door, the 5 resident accessible doors leading to stairway BG, the 5 resident accessible doors leading to stairway AG, beyond stairway AG, there is an exit door leading to the front of the building and beyond stairway BG there is an exit door leading to the back parking lot towards the Queensway. (550)

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

Jul 02, 2015

Ontario

**Ministry of Health and Long-Term Care**

## Order(s) of the Inspector

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

**Ministère de la Santé et des Soins de longue durée**

## Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

## 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

## 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

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 9 day of March 2015 (A1)**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** JOANNE HENRIE - (A1)

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