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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Jun 9, 2016	2016_189120_0033	016602-16	Critical Incident System

Licensee/Titulaire de permis

DEEM MANAGEMENT SERVICES LIMITED
2 QUEEN STREET EAST SUITE 1500 TORONTO ON M5C 3G5

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

HAMILTON CONTINUING CARE
125 WENTWORTH STREET SOUTH HAMILTON ON L8N 2Z1

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 1, 2016

Critical Incident #2912-000007-16 was reviewed related to a resident who sustained several injuries as a result of their window.

During the course of the inspection, the inspector(s) spoke with the Administrator, Environmental Services Supervisor and maintenance person.

During the course of the inspection, the inspector reviewed details of the incident and resident clinical history, observed the window in the identified resident's room, toured around the exterior of the building and observed the condition of the majority of the windows, reviewed maintenance procedures and randomly tested several windows for function.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

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

- **1 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. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and O. Reg. 79/10, s. 90 (1).
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee did not ensure that there were schedules in place for preventive maintenance related to the home's windows.

The majority of the home's windows were made of wood and located on the basement level, 1st and 2nd floors. The majority of the windows were casement style, with an operator crank or handle to allow the window to open along an operating track. However, due to security and safety reasons, the licensee removed the handles from all of the windows in the home prior to the incident.

In May 2016, an identified resident removed a window screen, unlocked the casement window and pushed it wide open (greater than 15 cm) with their hands. The resident sustained several injuries shortly thereafter. No operator handle was available and an operating track was missing. The operating track, when tested on other windows, did not allow the window to open more than 15 cm. If the operator track was attached and in good working order for the window used by the resident, it would have prevented the resident from opening the window more than 15 cm. All windows made of wood and located below the 3rd floor were observed to be in poor condition with flaking paint and wood rot. Windows located on the 1st floor and basement level were in worse condition than those on 2nd floor, some with holes in the exterior trim and into the bottom sill. The wood was crumbly and not sealed (painted or varnished). Some of the wood trim was so loose it was removed by hand.

The licensee did not have any schedules in place to ensure the windows were inspected once per year and repaired if necessary as identified in their window related policies #1166 and #1402. The maintenance person who had been employed 11 months reported that he had not inspected the windows prior to the incident noted above and that none were scheduled and no records were kept regarding any previous inspections. The maintenance person checked all of the casement windows for missing hardware post incident and did not find any others. The window used by the resident was sealed post incident to prevent anyone from pushing the window open until it could be repaired. [s. 90. (1)]

This Order is made based upon the application of 3 factors (severity, scope and compliance history) in keeping with s. 299(1) of the Long Term Care Home Regulation 79/10. The severity of the non compliance was 3 (actual harm of the resident), the scope was 1 (isolated) and the compliance history was 2 (previous non compliance issued but was unrelated).

Additional Required Actions:

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

Issued on this 10th day of June, 2016

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2016_189120_0033
Log No. / Registre no:	016602-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 9, 2016
Licensee / Titulaire de permis :	DEEM MANAGEMENT SERVICES LIMITED 2 QUEEN STREET EAST, SUITE 1500, TORONTO, ON, M5C-3G5
LTC Home / Foyer de SLD :	HAMILTON CONTINUING CARE 125 WENTWORTH STREET SOUTH, HAMILTON, ON, L8N-2Z1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Enesia Malapela

To DEEM MANAGEMENT SERVICES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Order / Ordre :

1. The licensee shall complete an assessment, in accordance with the licensee's policies #1166 and #1402 of all windows for condition and function and document the required remediation needs for each window.
2. The disrepair, malfunctions or missing hardware identified in the assessment above shall be scheduled for immediate remediation if based on safety followed by the remaining repairs. Documentation shall be kept as to the work completed including dates and person who completed the work.
3. All wood windows shall be adequately sealed to prevent the entry of moisture and wind. Any rotten, soft or damaged wood components of the window shall be removed and replaced, any missing trim replaced, wood trim sanded and sealed (painted and caulked) or clad with aluminum and caulked where necessary.

Grounds / Motifs :

1. The licensee did not ensure that there were schedules in place for preventive maintenance related to the home's windows.

The majority of the home's windows were made of wood and located on the basement level, 1st and 2nd floors. The majority of the windows were casement style, with an operator crank or handle to allow the window to open along an operating track. However, due to security and safety reasons, the licensee removed the handles from all of the windows in the home prior to the incident.

In May 2016, an identified resident removed a window screen, unlocked the casement window and pushed it wide open (greater than 15 cm) with their hands. The resident sustained several injuries shortly thereafter. No operator handle was available and an operating track was missing. The operating track, when tested on other windows, did not allow the window to open more than 15 cm. If the operator track was attached and in good working order for the window used by the resident, it would have prevented the resident from opening the window more than 15 cm. All windows made of wood and located below the 3rd floor were observed to be in poor condition with flaking paint and wood rot. Windows located on the 1st floor and basement level were in worse condition than those on 2nd floor, some with holes in the exterior trim and into the bottom sill. The wood was crumbly and not sealed (painted or varnished). Some of the wood trim was so loose it was removed by hand.

The licensee did not have any schedules in place to ensure the windows were inspected once per year and repaired if necessary as identified in their window related policies #1166 and #1402. The maintenance person who had been employed 11 months reported that he had not inspected the windows prior to the incident noted above and that none were scheduled and no records were kept regarding any previous inspections. The maintenance person checked all of the casement windows for missing hardware post incident and did not find any others. The window used by the resident was sealed post incident to prevent anyone from pushing the window open until it could be repaired.

This Order is made based upon the application of 3 factors (severity, scope and compliance history) in keeping with s. 299(1) of the Long Term Care Home Regulation 79/10. The severity of the non compliance was 3 (actual harm of the resident), the scope was 1 (isolated) and the compliance history was 2 (previous non compliance issued but was unrelated). (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 15, 2016

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, 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 9th day of June, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BERNADETTE SUSNIK

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