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

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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 12, 2016	2016_346133_0027	013727-16, 004595-16	Follow up

Licensee/Titulaire de permis

CVH (No.4) GP Inc. as general partner of CVH (No.4) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Inc. CAMBRIDGE ON N3H 5L8

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

MANOIR MAROCHEL
949 MONTREAL ROAD OTTAWA ON K1K 0S6

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): June 24, 27, 28 - 2016

This Follow Up Inspection was related to two past due Compliance Orders, relating to the resident-staff communication and response system, and to the requirement for a Registered Nurse to be on duty and present in the home at all times (excluding the Director of Nursing and Personal Care). The Compliance Orders are complied as a result of the inspection. A Compliance Order, related to door security, was issued as a result of the inspection. As well, findings of non compliance related to maintenance, and to the management of the resident's environment during periods of hot weather, were also issued as a result of the inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the acting Director of Care, the Maintenance Worker, the RAI coordinator, and registered and non registered nursing staff.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 17. (1)	CO #001	2016_346133_0018	133
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #002	2015_286547_0025	133

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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

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

Specifically failed to comply with the following:

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).

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).

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 stairways, and all doors leading to the outside of the home, other than doors leading to secure outside areas that preclude exit by a resident, or doors that the residents do not have access to, are kept closed and locked.

On June 27th, 2016, at 1015 hrs, the Inspector noted that the west unit exit door that leads to the garden patio was propped open with a patio stone. There was a sign on the

door that read "this door must be kept closed at all times (do not prop open)". Resident #001 was seated in her/his Broda chair, positioned to look out the door. Resident #001 is not independently mobile. While there were two Personal Support Workers (PSWs) working in the general area, #S101 and #S102, neither were directly supervising the open door. The Inspector went outside to the garden patio and noted that although the area was enclosed by a fence, the fence was not secured. There was a latch on the gate, but it was not locked. To open the gate, the Inspector lifted up the latch mechanism. While the Inspector was outside, a Registered Nurse, RN #S103, directed PSW #S102 to close the door.

The Administrator confirmed that the door is a designated fire exit, and therefore the fence gate cannot be secured so as to preclude exit. The west patio garden is therefore not a secure outside area, requiring the door to be kept closed and locked as prescribed. [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 doors leading to stairways, and all doors leading to the outside of the home, other than doors leading to secure outside areas, or doors that the residents do not have access to, are equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and, A. connected to the resident-staff communication and response system, or, B. connected to an audio visual enunciator that is connected to the nurses' station nearest to the door with a manual reset switch at each door.

On June 27th, 2016, at 1015 hrs, the Inspector noted that the west unit exit door that leads to the garden patio was propped open with a patio stone. There was a sign on the door that read "this door must be kept closed at all times (do not prop open)". Resident #001 was seated in her/his Broda chair, positioned to look out the door. Resident #001 is not independently mobile. While there were two Personal Support Workers (PSWs) working in the general area, #S101 and #S102, neither were directly supervising the open door. The Inspector went outside to the garden patio and noted that although the area was enclosed by a fence, the fence was not secured. There was a latch on the gate, but it was not locked. To open the gate, the Inspector lifted up the latch mechanism. While the Inspector was outside, a Registered Nurse, RN #S103, directed PSW #S102 to close the door.

The Administrator confirmed that the door is a designated fire exit, and therefore the fence gate cannot be secured so as to preclude exit. The west patio garden is therefore

not a secure outside area, requiring the door to be kept closed and locked, and equipped with an audible door alarm as prescribed.

On June 28th, 2016, the Inspector verified if the home's six applicable doors, on the main level, were equipped with alarms as prescribed. This was done by holding each door open for five minutes, in attempts to activate an alarm. Prior to conducting this testing, the Administrator indicated that he did not think any of the doors were equipped with alarms.

The front door was not equipped with an alarm. It was noted that the Wanderguard system was in place at the door. This system serves as a safety measure only for those residents who wear a bracelet connected to the system, and does not satisfy the requirements for a door alarm as per O. Reg. 79/10, s. 9 (1) 1. iii.

The West stairway door was not equipped with an alarm. The door led to a stairway that led to the basement, which is an area accessed by residents.

The West patio garden exit door was not equipped with an alarm. The garden fence gate opened to a wooded area behind the home.

The West exit door was not equipped with an alarm. The door led directly to a vestibule in which there was an unlocked door leading to the outdoors, and an unlocked door leading to a barber shop and a massage therapy clinic. This commercial section of the building complex is considered to be the outside of the home for the purposes of O. Reg. 79/10, s. 9(1)1.

The South patio exit door was not equipped with an alarm. This door led to a space enclosed by a fence, with a gate that was not locked. This door is also a designated fire exit. The South patio was therefore not a secure outside area that precludes exit by a resident, requiring the door to be equipped with an audible door alarm as prescribed. The South patio is approximately 20 feet from the sidewalk along Montreal Road, a busy four lane road.

The South exit door was not equipped with an alarm. This door led directly to the outdoors, onto the entrance driveway that leads to the parking lot, approximately 40 feet from Montreal road.

At the end of the inspection day, on June 28th, 2016, it was noted that the Administrator

had changed the door access code for the South and West exit doors and the South and West patio exit doors. The Administrator explained he also intended to change the access code for the West stairway door. The Administrator explained that he intended that only he and the maintenance worker would know the access codes for the doors, which would prevent routine use of the doors by staff. The Administrator explained that he felt this would decrease the potential risk in light of the fact that the doors were not equipped with alarms.

As a result of the widespread nature of the potential risk to residents in light of the absence of door alarms on all applicable doors on the main level, a Compliance Order will be served to the licensee. [s. 9. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 comply with LTCHA, 2007, S.O. 2007, c. 8, s. 15 (2) (c) in that the licensee has failed to ensure that the home, furnishings and equipment are maintained in safe condition and in a good state of repair.

The licensee was served with a Compliance Order (CO), #001, pursuant LTCHA, 2007, S.O. 2007, c. 8, s. 15 (2) (c) on August 24th, 2015 as a result of Follow Up inspection #2015_346133_0029. Full compliance for the CO is due on August 22, 2016. The

licensee was subsequently issue a Written Notification (#1) on October 22, 2015 as a result of Follow Up inspection #2015_346133_0040, and a Written Notification (#15) on January 25, 2016 as a result of Resident Quality Inspection #2015_286547_0025. The findings that supported the Written Notifications were presented as additional information for CO #001.

The evidence presented below is additional information for CO #001, and will be included in the Follow Up inspection.

On June 24th, 2016, the Inspector observed that the arms rests of the raised toilet seat in the bathroom of bedroom #147 had been wrapped with duct tape. On the left side (when facing the toilet) the duct tape was dirty with dried brown matter and was unravelling. On June 28th, 2016, the Administrator accompanied the Inspector into the bathroom and the raised toilet seat arms were observed to be in the same condition.

On June 24th, 2016, the Inspector observed that in the bathroom of bedroom #104, there was accumulation of thick brown matter between floor tiles throughout the bathroom, most concentrated in the area in front of the toilet. The home's new maintenance worker accompanied the Inspector to the bathroom to observe the condition of the floor.

The licensee has a history of non-compliance specifically related to the accumulation of brown matter between bathroom floor tiles (as previously referenced, inspection #2015_346133_0029).

On June 24th, 2016, while conducting an audit of resident-staff communication and response system (the system) activation cords in resident bedrooms and bathrooms, the Inspector observed there was no activation cord in the bathroom of bedroom #112. Later that day, the Inspector reviewed a documented audit of the system, the "pager call bell audit", conducted by the former Director of Care, on May 20th, 2016. On the back of the audit, it was noted "112-no pull cord in washroom". The Inspector reported the missing cord to the office manager, the maintenance worker, and the Administrator, that day. On June 28th, 2016, the maintenance worker informed the Inspector that he did not any of the cord in stock and that it would have to be ordered.

The licensee has a history of non-compliance specifically related to the system activation cords (as previously referenced, inspection #2015_346133_0040, and #2015_286547_0025).

On June 27th, while reviewing documented audits of the system (“pager call bell audit”), conducted by the former Director of Care on May 19th, 2016 and on June 6th, 2016, the Inspector noted that it had been documented that the dome light outside of the west activity room was not functional. The Inspector confirmed that the dome light was still non-functional. On June 28th, 2016, the maintenance worker indicated he had a replacement bulb, and would try to replace the bulb in order to correct the problem. By the end of the inspection day, the dome light remained non-functional.

On June 27th, 2016, the Inspector noted that in the short length of the west hallway, between the shower room and bedroom #127, there were at least seven areas where the vinyl sheet flooring was not adhered to the surface below. As a result, the flooring was raised and bubbled, presenting a potential tripping hazard. The hallway flooring between the shower room and the tub room was the most significantly raised. The home was experiencing an internal humidity level of 69% on that day, which may have contributed to the feeling of stickiness on the flooring surface, further increasing the potential tripping hazard.

The licensee has a history of non-compliance specifically related to the lack of adhesion of the vinyl hallway flooring to the surface below (as previously referenced, inspection #2015_346133_0029). [s. 15. (2) (c)]

WN #3: 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 comply with O. Reg. 79/10, s. 20 (1) in that the licensee has failed to ensure that a written hot weather related illness prevention and management

plan for the home is developed in accordance with evidence-based practices and is implemented when required.

This finding of non-compliance is specifically related to the management of the resident's environment, excluding air conditioned areas, during a period of hot weather, on Monday, June 27th, 2016. The home is served by air conditioning in the main lobby, in both unit dining rooms, and both unit activity rooms. The hallways and resident bedrooms are not air conditioned.

At approximately 1030 hour, in bedroom #129, at the end of the short length of the West wing hallway, the Inspector observed that although the heat radiator dial was in the off position, the radiator was generating heat. The Inspector measured the temperature in the bedroom to be at 27.8C, in the area of resident #001's bed pillow.

At 1054 hours, on the wall outside of the West wing hallway nurses station, it was observed that the thermostat reflected a temperature of 82 degrees Fahrenheit (27 degrees Celsius). The hygrometer on the wall, in the West wing hallway, between bedrooms #115 and #117, reflected a temperature of 27.7 degrees Celsius (C), and a relative humidity (RH) level of 69%. Combined, these two factors result in a humidex reading of approximately 35C.

At approximately 1120 hours, the Inspector heard a weather report on a radio station that was on in the home's main lobby, which stated that the outdoor temperature was currently at 24 C, with a humidex reading of 31C. It was a clear sunny day, with a breeze.

At approximately 1130 hours, in the South wing hallway, between bedrooms #106 and #108, it was observed that the hygrometer on the wall reflected a temperature of 28.5C and an RH of 67%. Combined, these two factors result in a humidex reading of approximately 36C.

In the South wing, in bedroom #120, the Inspector observed that although the heat radiator dial was in the off position, the radiator was generating heat. In bedrooms #118 and #100, the heat radiator dial was at 5, the highest position, and the radiator was generating heat. The temperature in bedroom #100, at the resident's pillow, was measured at 28.4C. In bedroom #110, there was a hygrometer on the wall within the entrance to the bedroom, reflecting a temperature of 28C and an RH of 63%, for a humidex reading of approximately 35C.

The Inspector spoke with the Administrator and the maintenance worker to inform that the heat was on in the bedrooms noted above. The Administrator indicated that approximately 15 days prior, he had asked that the boiler that serves the heat system in resident bedrooms be turned off. The maintenance worker explained that at some point during the week of June 20th, 2016, the home's RAI coordinator had requested the system be turned back on. The maintenance worker confirmed that the system had not been turned back off, despite the hot weather.

The licensee has a history of non-compliance related to the heating system in bedrooms in the summer. As noted on August 12th, 2015, during inspection # 2015_346133_0029, the Inspector found that the heat was on in bedrooms #129 and #127. Attempts were made to turn off the heat by turning a lever below the radiator on that day. On August 13th, 2015, the Inspector found that the heat remained on in the bedrooms. This issue was captured within the grounds that supported Compliance Order #001, served on the licensee on August 24th, 2015 , which has a compliance date of August 22, 2016.

Related to the monitoring of the home's internal temperature and humidity levels, Registered Nurse #S103 explained to the Inspector that once per shift, a registered nurse will record and document the temperature and humidity within one resident bedroom. As well, on the day shift, the temperature and humidity as per the one hallway hygrometer is documented. On odd days, this is done in the West wing and on even days, it is done in the South wing. The information is entered on an "air temperature and humidity log" sheet, contained within a clipboard in the South wing nurses' station. On the lower left area of the log sheet, it was written "notify maintenance/administrator if temperature is below 22 degrees Celsius, or humidex is high. Put note in maintenance book". On the June 2016 log sheet, and amongst the various other sheets within the clipboard, there was no information about how to calculate the humidex, or what level would constitute a high humidex. The humidex had not been calculated for any of the temperature and humidity readings recorded on the June 2016 log sheet. As it was an odd numbered day (June 27th, 2016), RN #103 had recorded the temperature and humidity in one bedroom and in the hallway in the West wing. The process therefore did not capture the temperature and humidity levels in the South wing on that day. As well, the process only captured the daytime temperature and humidity level in the hallway in the West wing.

It was verified that the humidex level of approximately 35C in the West wing hallway on that day had not been communicated to the Administrator or to the maintenance worker.

In conversation with the Administrator and the maintenance worker, it was verified that there was no formalized plan in place, with regards to the management of the environment, to be implemented based on humidex levels. The Administrator proposed opening all the resident windows, as there was a breeze outside, in the hopes of reducing the internal humidity. The possibility of temporarily shutting down the fresh air intake system, in response to a high humidex reading, was also discussed. Each hallway is served by eight fresh air intake vents, and it could not be determined if there was any system in place to temper the incoming outside air. There is no mechanical exhaust system serving the hallways.

Generally, throughout the home, window blinds were raised, which allowed the sun to further heat the home, and the windows were closed, despite the outside breeze and high internal humidity. There was no formalized process in place to have all window blinds closed, or to open windows, during the day or night, in order to maximize ventilation, when conditions would favor such an approach.

Towards the end of the inspection day, the home's acting Director of Care (DOC), #S104, confirmed to the Inspector that the Extendicare policies within the "heat assessment" binder, as had provided to the Inspector by RN #103, were to be taken collectively as the written hot weather related illness prevention and management plan for the home. Related to hot weather management, the policies were as follows: # CLIN-05-01-01; CLIN-05-01-02; CLIN-05-01-03; CLIN-05-01-04; CLIN-05-01-04A; CLIN-05-01-04B; CLIN-05-01-04C1; CLIN-05-01-04C2; and CLIN-05-01-05. The policies all had an implementation and review date of December 2002. The acting DOC indicated that she believed the policies were currently under revision or would be soon. The acting DOC identified that although the MOHLTC "Guidelines for the Prevention and Management of Hot Weather Related Illness in Long Term Care Homes, July 2012" was in the binder, it was not to be seen as the licensee's hot weather related illness prevention and management plan.

On June 28th, 2016, the acting DOC provided the Inspector with the "hot weather checklist", upon request, as was referenced within a memo (dated June 1, 2016) from Extendicare to "All Canadian Operations" regarding" Hot Weather Policies". The memo was found by the Inspector within the "heat assessment" binder. The checklist was not dated or numbered. Under the physical plant maintenance section, it was indicated to "implement strategies to maximize ventilation" and to "implement routine checks to

assess indoor temperatures and humidex levels and communicate results to Administrator/DOC".

The Extendicare policies fail to specifically address humidex levels and do not provide guidance to the home's staff on when and where to monitor temperature and humidity levels. Policy #CLIN-05-01-05 only references the need to have a portable thermometer and a humidity measuring device. Policy #CLIN-05-01-02 does however set out that preventive measures against heat related illness (vs. emergency measures) are the required type of intervention at a temperature of 28C with dry air (less that 50% RH) or 26C with humid air (more than 50%). The policy outlines that preventive measures related to the resident environment include "close the windows, drapes and blinds during the day, and open them at night".

On June 27th, 2016, the home had not implemented a plan that included effective preventive measures for keeping the building as cool as possible, such as turning the heating system off, keeping all window blinds down to block out the sun, and using windows to maximize ventilation, as applicable, in advance of a period of high heat and humidity. [s. 20. (1)]

Issued on this 12th day of July, 2016

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

Original report signed by the inspector.

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) :	JESSICA LAPENSEE (133)
Inspection No. / No de l'inspection :	2016_346133_0027
Log No. / Registre no:	013727-16, 004595-16
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jul 12, 2016
Licensee / Titulaire de permis :	CVH (No.4) GP Inc. as general partner of CVH (No.4) LP 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes Inc., CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	MANOIR MAROCHEL 949 MONTREAL ROAD, OTTAWA, ON, K1K-0S6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bipin Raut

To CVH (No.4) GP Inc. as general partner of CVH (No.4) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

   i. kept closed and locked,

   ii.equipped with a door access control system that is kept on at all times, and

   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

      A. is connected to the resident-staff communication and response system, or

      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

1. In order to comply with O. Reg. 79/10, s. 9 (1) 1. i, the licensee shall 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 kept closed and locked.

2. In order to comply with O. Reg. 79/10, s. 9 (1) 1. iii, the licensee shall 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, 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.

This is specifically related to the front door, the South and West exit doors, the South and West patio doors, the West stairway door, and any applicable doors within the basement.

The licensee will take note that once a door alarm is activated, the alarm must remain active once the door closes. A door alarm must not "self cancel". A door alarm must only allow for cancellation at the door itself, which is the point of activation.

When considering the length of an alarm delay, the licensee must ensure that overall, the home is a safe and secure environment for its residents, as per the LTCHA, 2007, S.O. 2007, c.8, s. 5.

Until such time as compliance is achieved, the licensee will ensure that formalized measures are in place to ensure resident safety in light of the lack of audible alarms in place at the noted doors, as prescribed by O. Reg. 79/10, s. 9 (1).

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 doors leading to stairways, and all doors leading to the outside of the home, other than doors leading to secure outside areas, or doors that the residents do not have access to, are equipped with an audible door alarm that allows calls to be cancelled only at the point of activation

and, A. connected to the resident-staff communication and response system, or, B. connected to an audio visual enunciator that is connected to the nurses' station nearest to the door with a manual reset switch at each door.

On June 27th, 2016, at 1015 hrs, the Inspector noted that the west unit exit door that leads to the garden patio was propped open with a patio stone. There was a sign on the door that read “this door must be kept closed at all times (do not prop open)”. Resident #001 was seated in her/his Broda chair, positioned to look out the door. Resident #001 is not independently mobile. While there were two Personal Support Workers (PSWs) working in the general area, #S101 and #S102, neither were directly supervising the open door. The Inspector went outside to the garden patio and noted that although the area was enclosed by a fence, the fence was not secured. There was a latch on the gate, but it was not locked. To open the gate, the Inspector lifted up the latch mechanism. While the Inspector was outside, a Registered Nurse, RN #S103, directed PSW #S102 to close the door.

The Administrator confirmed that the door is a designated fire exit, and therefore the fence gate cannot be secured so as to preclude exit. The west patio garden is therefore not a secure outside area, requiring the door to be kept closed and locked, and equipped with an audible door alarm as prescribed.

On June 28th, 2016, the Inspector verified if the home's six applicable doors, on the main level, were equipped with alarms as prescribed. This was done by holding each door open for five minutes, in attempts to activate an alarm. Prior to conducting this testing, the Administrator indicated that he did not think any of the doors were equipped with alarms.

The front door was not equipped with an alarm. It was noted that the Wanderguard system was in place at the door. This system serves as a safety measure only for those residents who wear a bracelet connected to the system, and does not satisfy the requirements for a door alarm as per O. Reg. 79/10, s. 9 (1) 1. iii.

The West stairway door was not equipped with an alarm. The door led to a stairway that led to the basement, which is an area accessed by residents.

The West patio garden exit door was not equipped with an alarm. The garden fence gate opened to a wooded area behind the home.

The West exit door was not equipped with an alarm. The door led directly to a vestibule in which there was an unlocked door leading to the outdoors, and an unlocked door leading to a barber shop and a massage therapy clinic. This commercial section of the building complex is considered to be the outside of the home for the purposes of O. Reg. 79/10, s. 9(1)1.

The South patio exit door was not equipped with an alarm. This door led to a space enclosed by a fence, with a gate that was not locked. This door is also a designated fire exit. The South patio was therefore not a secure outside area that precludes exit by a resident, requiring the door to be equipped with an audible door alarm as prescribed. The South patio is approximately 20 feet from the sidewalk along Montreal Road, a busy four lane road.

The South exit door was not equipped with an alarm. This door led directly to the outdoors, onto the entrance driveway that leads to the parking lot, approximately 40 feet from Montreal road.

At the end of the inspection day, on June 28th, 2016, it was noted that the Administrator had changed the door access code for the South and West exit doors and the South and West patio exit doors. The Administrator explained he also intended to change the access code for the West stairway door. The Administrator explained that he intended that only he and the maintenance worker would know the access codes for the doors, which would prevent routine use of the doors by staff. The Administrator explained that he felt this would decrease the potential risk in light of the fact that the doors were not equipped with alarms.

As a result of the widespread nature of the potential risk to residents in light of the absence of door alarms, a Compliance Order will be served to the licensee. (133)

2. 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 stairways, and all doors leading to the outside of the home, other than doors leading to secure outside areas that preclude exit by a resident, or doors that the residents do not have access to, are kept closed and locked.

On June 27th, 2016, at 1015 hrs, the Inspector noted that the west unit exit door

that leads to the garden patio was propped open with a patio stone. There was a sign on the door that read “this door must be kept closed at all times (do not prop open)”. Resident #001 was seated in her/his Broda chair, positioned to look out the door. Resident #001 is not independently mobile. While there were two Personal Support Workers (PSWs) working in the general area, #S101 and #S102, neither were directly supervising the open door. The Inspector went outside to the garden patio and noted that although the area was enclosed by a fence, the fence was not secured. There was a latch on the gate, but it was not locked. To open the gate, the Inspector lifted up the latch mechanism. While the Inspector was outside, a Registered Nurse, RN #S103, directed PSW #S102 to close the door.

The Administrator confirmed that the door is a designated fire exit, and therefore the fence gate cannot be secured so as to preclude exit. The west patio garden is therefore not a secure outside area, requiring the door to be kept closed and locked as prescribed.
(133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 14, 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
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
Inspection de soins de longue durée
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 12th day of July, 2016

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : JESSICA LAPENSEE

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