Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 31, 2013	2013_204133_0012	O-002376-12	Critical Incident System

Licensee/Titulaire de permis

MAXVILLE MANOR
80 Mechanic Street, MAXVILLE, ON, K0C-1T0

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

MAXVILLE MANOR
80 MECHANIC STREET WEST, MAXVILLE, ON, K0C-1T0

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): May 8th, 9th 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Environmental Services Manager, registered and non registered nursing staff and dietary services staff.

During the course of the inspection, the inspector(s) reviewed a Critical Incident Report and inspected the home with a focus on door security.

The following Inspection Protocols were used during this inspection:

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Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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. 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, s.17(1)d in that the resident-staff communication and response system is not available at each toilet used by residents.

Upon arrival into the home, on May 8th 2013, the inspector noted that the resident-staff communication and response system is not available at the toilets in the two wheelchair accessible washrooms located around the corner from the main activity room and to the side of the main front area of the home known as the "Town Square". The inspector observed that the doors into these washrooms were open, except for when in use, over the course of the 2 day inspection. [s. 17. (1) (d)]

2. The licensee has failed to comply with O. Reg. 79/10, s. 17(1)(e) in that the resident -staff communication and response system is not available in every area accessible by residents.

Over the course of the 2 day inspection, May 8th-9th 2013, the inspector observed that the resident-staff communication and response system is not available in the following areas: the Vera MacGregor Chapel, Piper's Lounge, the front sitting area of the home known as Town Square, the Kenyon (F unit) dining room, the Roxborough (G unit) dining room, the Roxbrorough (G unit) activity room and the Osie F. Villeneuve activity room. All of these areas are readily accessible to residents. [s. 17. (1) (e)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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. O. Reg. 79/10, s. 9. (1).
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. O. Reg. 79/10, s. 9. (1).
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. (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10, s.9(1)1.i. in that not all resident accessible doors that lead to unsecured outdoor areas are kept closed and locked.

During the inspection, at 12:30pm on May 8th 2013, the inspector found the resident accessible exit door within the Osie F. Villeneuve activity room was not locked. This door leads to the outside of the home, and the area is not a secure outside area that precludes exit by a resident. There is a small slide bolt style lock on the upper right door frame and staff member #S100 used this to secure the door after the inspector found it unlocked. [s. 9. (1) 1. i.]

2. The licensee has failed to comply with O. Reg. 79/10, s.9(1)1.ii in that not all resident accessible doors leading to unsecured outdoor space are equipped with a door access control system that is kept on at all times.

During the inspection, at 12:30pm on May 8th 2013, the inspector found the resident accessible exit door within the Osie F. Villeneuve activity room was not locked. This door leads to the outside of the home, and the area is not a secure outside area that precludes exit by a resident. There is a small slide bolt style lock on the upper right door frame, however this lock can be easily disengaged and it does not prevent unauthorized exiting from the home. It is not a door access control system. The exit door is also equipped with panic bar, which can be locked and can be considered as a door access control system. The inspector was informed, by staff member #S100, that the night nurse carries the key to this door and locks it during night shift rounds. While the door is equipped with a door access control system, it is not kept on at all times. [s. 9. (1) 1. ii.]

3. The licensee has failed to comply with O. Reg. 79/10, s.9(1)1.iii in that not all resident accessible doors leading to stairways and 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: (A) the resident–staff communication and response system, or (B) an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

During the inspection, on May 8th 2013, the inspector noted that the main exit door, at the front of the home, which is accessible to residents and leads to the outside of the

home, is not equipped with an audible door alarm.

During the inspection, on May 8th 2013, the inspector noted that the resident accessible door that leads to a stairway, in the service area to the left of the Prescott care unit nurse station, is not equipped with an audible door alarm.

During the inspection, on May 8th and 9th 2013, the inspector noted that resident accessible exit doors, within care units and a service area, that lead to unsecured areas outside of the home that do not preclude exit by a resident, are not equipped with audible door alarms. This pertains specifically to the two exit doors within the Prescott care unit, the exit door within the Osie F. Villeneuve (OFV) care unit, the exit door within the OFV activity room, the exit door within the "A" service area (near the old basement) and the exit door within the Kenyon care unit. It is however noted that opening these doors does trigger the resident–staff communication and response system (which is not the case for the home's front exit door and the door that leads to a stairway in the service area to the left of the Prescott care unit nurse station). Nursing staff receive notification if an exit door has been opened on their pager phones and sound is emitted from a wall mounted resident-staff communication and response system console in the general vicinity of the door. For example, in the Prescott care unit, the console is in the lounge close to the end of the hallway, in the OFV care unit the console is approximately mid way down the hallway, and in the "A" service area the console is within the tub room near the OFV nurse station (and therefore the sound is not heard at the exit door). Staff cancel the notification that an exit door has been opened by pressing a button on the side of the console. The resident accessible exit doors referred to above must be equipped with audible door alarms. These door alarms must only allow calls to be cancelled at the point of activation. The point of activation of a door alarm is at the door itself.

Note: The inspector was unable to ascertain if the resident accessible exit door at the end of the Roxborough care unit, and the resident accessible exit door next to Piper's Lounge within the Kenyon/Roxborough area of the home, both of which to outdoor unsecured areas, are equipped with alarms as is required. [s. 9. (1) 1. iii.]

4. The licensee has failed to comply with O. Reg. 79/10, s.9(1)2 in that doors leading to non-residential areas are not kept locked in order to restrict unsupervised access to the areas by residents. Widespread evidence of this failure to lock doors leading to non -residential areas was found during the inspection and this presents a potential

risk to the residents' safety. In November 2012, a resident was injured after they gained unsupervised access to an unlocked non-residential area.

As reported in a Critical Incident Report, on a day in November 2012, resident #001 was found lying face down on the floor in a soiled utility room with injuries. Resident #001 was subsequently transferred to hospital for assessment of their injuries. On May 8, 2013, during the inspection, the Director of Care indicated to the inspector that the door into the soiled utility room had been left unlocked by staff during a shift change on the day in November 2012 and the room was not being supervised during this time, thereby allowing resident #001 unsupervised access to the area. The soiled utility room where resident #001 was found is within an identified care unit.

On May 8th 2013, during the inspection, at approximately 11:36, the inspector found the door into a room labeled as a clean utility room (door #502), in the Prescott care unit, unlocked. There was no staff supervising the area at the time. The room was noted to contain continence products and linens. While the door (#502) is equipped with a lock, the lock was not engaged in order to restrict unsupervised access to the area by residents.

On May 8th 2013, during the inspection, at approximately 11:42, the inspector found the door into the wheelchair services room (door #107) unlocked. There was no staff supervising the area at the time. This room is to the left of the Prescott care unit nurse station. The room was noted to contain a large maintenance cart with a variety of items on/within it such as wrenches, pliers, screws, nails, electrical cords, light bulbs and a spray can of "Raid Max crawling insect bug killer". Cans of paint, 2 vacuums and fluorescent light bulbs were also noted in the room. While the door (#107) is equipped with a lock, the lock was not engaged in order to restrict unsupervised access to the area by residents.

On May 8th, 2013, during the inspection, at approximately 11:53, the inspector found the door into a soiled linen room (door #106) unlocked. There was no staff supervising the area at the time. This room is to the left of the Prescott care unit nurse station. The room was noted to contain large linen carts with bags of soiled laundry on them. While the door (#106) is equipped with a lock, the lock was not engaged in order to restrict unsupervised access to the area by residents.

On May 8th, 2013, during the inspection, at approximately 12:59, the inspector found

the door into a soiled utility room (door #162) unlocked. There was no staff supervising the area at the time. This room is in the immediate area of the Osie F. Villeneuve care unit nurse station. The room was noted to contain a hopper (used for emptying bedpans) , a "Cyclo Flush" bedpan washer, a soiled linen cart with bags of soiled linen in it, and personal care supplies in the cupboards above the sink such as denture cleaner, zinc, lotion and gloves. While the door (#162) is equipped with a lock, the lock was not engaged in order to restrict unsupervised access to the area by residents.

On May 8th, 2013, during the inspection, at approximately 13:05, the inspector found the door into a room labeled as a clean utility room (door #163) unlocked. There was no staff supervising the area at the time. This room is in the immediate area of the Osie F. Villeneuve care unit nurse station. The room was noted to contain a dryer, a folding table and a large upright linen carts with clean clothing hanging on it. This room leads into another room, the laundry room, which was noted to contain a washing machine, resident's soiled clothing in bags, and laundry chemicals in buckets hooked up to the washing machine, such as a concentrated chlorinated liquid bleach compound and a concentrated laundry detergent with enzymes. The inspector noted that the door (#164) that leads directly into the laundry room was locked, yet the door into the room labeled as the clean utility room (#163), which leads into the laundry room, was not. A staff person (#S101) indicated to the inspector that this was the normal practice. While the door (#163) is equipped with a lock, the lock was not engaged in order to restrict unsupervised access to the area by residents.

On May 8th, 2013, during the inspection, at approximately 15:10, the inspector found the door from the D/E dining room, into the kitchenette, open and unlocked. There was no staff supervising the area at the time. The kitchenette is a fully equipped servery, containing food production and service equipment. The inspector noted that the steam table was on and hot to the touch at the time. A staff person (#S102) found the inspector within the room and explained that it is the normal practice to keep this door closed but not locked. The inspector noted a sign on the door which reads "please keep kitchenette door closed in between meal service". While the door into the D/E kitchenette is equipped with a lock, the lock was not engaged in order to restrict unsupervised access to the area by residents.

On May 9th, 2013, during the inspection, at approximately 10:31am, the inspector found the back door (#822) into the F/G kitchenette unlocked. There was no staff

supervising the area at the time. The kitchenette is a fully equipped servery, containing food production and service equipment. The inspector noted that the steam table was on and hot to the touch at the time. The inspector noted a jug containing a cleaning chemical (EcoLab "Ultra San sanitizer and destainer") connected to the dishwasher. The inspector noted, on the counter, next to the toaster, a spray bottle containing a cleaning chemical (Oasis Mikroklene, an iodophore germicide). The inspector noted, on the lower shelf of this counter, various jugs of cleaning chemicals and a spray bottle of EcoLab "Clinging Lime-a-way". A staff person (#S103) whom the inspector met in the service area outside of the kitchenette indicated that this door is normally kept unlocked. While the door (#822) is equipped with a lock, the lock was not engaged in order to restrict unsupervised access to the area by residents.

On May 9th, 2013, during the inspection, at approximately 14:35, the inspector found the door into a soiled utility room (door #501) unlocked. There was no staff supervising the area at the time. This room is within the Prescott care unit. The room was noted to contain a hopper (used for emptying bedpans) , a "Cyclo Flush" bedpan washer, a soiled linen cart with bags of soiled linen in it, a mechanical lift for resident transfers, and personal care supplies in the cupboards above the sink such as skin lotion, soap and razors. While the door (#501) is equipped with a lock, the lock was not engaged in order to restrict unsupervised access to the area by residents. [s. 9. (1) 2.]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 31st day of May, 2013

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

Jessica Lapensée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA LAPENSEE (133)
Inspection No. / No de l'inspection :	2013_204133_0012
Log No. / Registre no:	O-002376-12
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 31, 2013
Licensee / Titulaire de permis :	MAXVILLE MANOR 80 Mechanic Street, MAXVILLE, ON, K0C-1T0
LTC Home / Foyer de SLD :	MAXVILLE MANOR 80 MECHANIC STREET WEST, MAXVILLE, ON, K0C-1T0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CRAIG MUNRO

To MAXVILLE MANOR, 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. 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;

(b) is on at all times;

(c) allows calls to be cancelled only at the point of activation;

(d) is available at each bed, toilet, bath and shower location used by residents;

(e) is available in every area accessible by residents;

(f) clearly indicates when activated where the signal is coming from; and

(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).

Order / Ordre :

The licensee will ensure that the resident-staff communication and response system is made available at each toilet used by residents and in every area within the home accessible by residents.

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg.. 79/10, s.17(1)d in that the resident-staff communication and response system is not available at each toilet used by residents.

Upon arrival into the home, on May 8th 2013, the inspector noted that the resident-staff communication and response system is not available at the toilets in the two wheelchair accessible washrooms located around the corner from the main activity room and to the side of the main front area of the home known as the "Town Square". The inspector observed that the doors into these washrooms were open, except for when in use, over the course of the 2 day inspection. (133)

2. The licensee has failed to comply with O. Reg. 79/10, s. 17(1)(e) in that the resident-staff communication and response system is not available in every area accessible by residents.

Over the course of the 2 day inspection, May 8th-9th 2013, the inspector observed that the resident-staff communication and response system is not available in the following areas: the Vera MacGregor Chapel, Piper's Lounge, the front sitting area of the home known as Town Square, the Kenyon (F unit) dining room, the Roxborough (G unit) dining room, the Roxborough (G unit) activity room and the Osie F. Villeneuve activity room. All of these areas are readily accessible to residents. (133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2013

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 : 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.

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. (1).

Order / Ordre :

The licensee will ensure that all resident accessible door that lead to non residential areas are equipped with locks which are used in order to restrict unsupervised access to those areas by residents.

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg. 79/10, s.9(1)2 in that doors leading to non-residential areas are not kept locked in order to restrict unsupervised access to the areas by residents. Widespread evidence of this failure to lock doors leading to non -residential areas was found during the inspection and this presents a potential risk to the residents' safety. In November 2012, a resident was injured after they gained unsupervised access to an unlocked non-residential area.

As reported in a Critical Incident Report, on a day in November 2012, resident #001 was found lying face down on the floor in a soiled utility room, with injuries. Resident #001 was subsequently transferred to hospital for assessment of their injuries. On May 8, 2013, during the inspection, the Director of Care indicated to the inspector that the door into the soiled utility room had been left unlocked by staff during a shift change on the day in November 2012 and the room was not being supervised during this time, thereby allowing resident #001 unsupervised access to the area. The soiled utility room where resident #001 was found is within an identified care unit.

On May 8th 2013, during the inspection, at approximately 11:36, the inspector found the door into a room labeled as a clean utility room (door #502), in the Prescott care unit, unlocked. There was no staff supervising the area at the time. The room was noted to contain continence products and linens. While the door (#502) is equipped with a lock, the lock was not engaged in order to restrict unsupervised access to the area by residents.

On May 8th 2013, during the inspection, at approximately 11:42, the inspector found the door into the wheelchair services room (door #107) unlocked. There was no staff supervising the area at the time. This room is to the left of the Prescott care unit nurse station. The room was noted to contain a large maintenance cart with a variety of items on/within it such as wrenches, pliers, screws, nails, electrical cords, light bulbs and a spray can of "Raid Max crawling insect bug killer". Cans of paint, 2 vacuums and fluorescent light bulbs were also noted in the room. While the door (#107) is equipped with a lock, the lock was not engaged in order to restrict unsupervised access to the area by residents.

On May 8th, 2013, during the inspection, at approximately 11:53, the inspector

found the door into a soiled linen room (door #106) unlocked. There was no staff supervising the area at the time. This room is to the left of the Prescott care unit nurse station. The room was noted to contain large linen carts with bags of soiled laundry on them. While the door (#106) is equipped with a lock, the lock was not engaged in order to restrict unsupervised access to the area by residents.

On May 8th, 2013, during the inspection, at approximately 12:59, the inspector found the door into a soiled utility room (door #162) unlocked. There was no staff supervising the area at the time. This room is in the immediate area of the Osie F. Villeneuve care unit nurse station. The room was noted to contain a hopper (used for emptying bedpans) , a "Cyclo Flush" bedpan washer, a soiled linen cart with bags of soiled linen in it, and personal care supplies in the cupboards above the sink such as denture cleaner, zinc, lotion and gloves. While the door (#162) is equipped with a lock, the lock was not engaged in order to restrict unsupervised access to the area by residents.

On May 8th, 2013, during the inspection, at approximately 13:05, the inspector found the door into a room labeled as a clean utility room (door #163) unlocked. There was no staff supervising the area at the time. This room is in the immediate area of the Osie F. Villeneuve care unit nurse station. The room was noted to contain a dryer, a folding table and a large upright linen carts with clean clothing hanging on it. This room leads into another room, the laundry room, which was noted to contain a washing machine, resident's soiled clothing in bags, and laundry chemicals in buckets hooked up to the washing machine, such as a concentrated chlorinated liquid bleach compound and a concentrated laundry detergent with enzymes. The inspector noted that the door (#164) that leads directly into the laundry room was locked, yet the door into the room labeled as the clean utility room (#163), which leads into the laundry room, was not. A staff person (#S101) indicated to the inspector that this was the normal practice. While the door (#163) is equipped with a lock, the lock was not engaged in order to restrict unsupervised access to the area by residents.

On May 8th, 2013, during the inspection, at approximately 15:10, the inspector found the door from the D/E dining room, into the kitchenette, open and unlocked. There was no staff supervising the area at the time. The kitchenette is a fully equipped servery, containing food production and service equipment. The inspector noted that the steam table was on and hot to the touch at the

time. A staff person (#S102) found the inspector within the room and explained that it is the normal practice to keep this door closed but not locked. The inspector noted a sign on the door which reads "please keep kitchenette door closed in between meal service". While the door into the D/E kitchenette is equipped with a lock, the lock was not engaged in order to restrict unsupervised access to the area by residents.

On May 9th, 2013, during the inspection, at approximately 10:31am, the inspector found the back door (#822) into the F/G kitchenette unlocked. There was no staff supervising the area at the time. The kitchenette is a fully equipped servery, containing food production and service equipment. The inspector noted that the steam table was on and hot to the touch at the time. The inspector noted a jug containing a cleaning chemical (EcoLab "Ultra San sanitizer and destainer") connected to the dishwasher. The inspector noted, on the counter, next to the toaster, a spray bottle containing a cleaning chemical (Oasis Mikroklene, an iodophore germicide). The inspector noted, on the lower shelf of this counter, various jugs of cleaning chemicals and a spray bottle of EcoLab "Clinging Lime-a-way". A staff person (#S103) whom the inspector met in the service area outside of the kitchenette indicated that this door is normally kept unlocked. While the door (#822) is equipped with a lock, the lock was not engaged in order to restrict unsupervised access to the area by residents.

On May 9th, 2013, during the inspection, at approximately 14:35, the inspector found the door into a soiled utility room (door #501) unlocked. There was no staff supervising the area at the time. This room is within the Prescott care unit. The room was noted to contain a hopper (used for emptying bedpans) , a "Cyclo Flush" bedpan washer, a soiled linen cart with bags of soiled linen in it, a mechanical lift for resident transfers, and personal care supplies in the cupboards above the sink such as skin lotion, soap and razors. While the door (#501) is equipped with a lock, the lock was not engaged in order to restrict unsupervised access to the area by residents.
(133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 03, 2013

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

Order # / Ordre no : 003

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.

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. (1).

Order / Ordre :

The licensee will ensure that all doors leading to stairways, and doors leading to 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, are:
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.

The licensee must immediately ensure that all resident accessible doors that lead to unsecured outside areas are kept closed and locked. The licensee must immediately ensure that all resident accessible doors that lead to unsecured outside areas are equipped with a door access control system that is kept on at all times. The licensee will ensure that all resident accessible doors that lead to stairways or that lead to unsecured outside areas are alarmed as outlined in O. Reg. 79/10, s. 9(1)1.iii by September 30th 2013.

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg 79/10, s.9(1)1.i. in that not all resident accessible doors that lead to unsecured outdoor areas are kept closed and locked.

During the inspection, at 12:30pm on May 8th 2013, the inspector found the resident accessible exit door within the Osie F. Villeneuve activity room was not locked. This door leads to the outside of the home, and the area is not a secure outside area that precludes exit by a resident. There is a small slide bolt style lock on the upper right door frame and staff member #S100 used this to secure the door after the inspector found it unlocked. (133)

2. The licensee has failed to comply with O. Reg. 79/10, s.9(1)1.ii in that not all resident accessible doors leading to unsecured outdoor space are equipped with a door access control system that is kept on at all times.

During the inspection, at 12:30pm on May 8th 2013, the inspector found the resident accessible exit door within the Osie F. Villeneuve activity room was not

locked. This door leads to the outside of the home, and the area is not a secure outside area that precludes exit by a resident. There is a small slide bolt style lock on the upper right door frame, however this lock can be easily disengaged and it does not prevent unauthorized exiting from the home. It is not a door access control system. The exit door is also equipped with panic bar, which can be locked and can be considered as a door access control system. The inspector was informed, by staff member #S100, that the night nurse carries the key to this door and locks it during night shift rounds. While the door is equipped with a door access control system, it is not kept on at all times. (133)

3. The licensee has failed to comply with O. Reg. 79/10, s.9(1)1.iii in that not all resident accessible doors leading to stairways and 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: (A) the resident–staff communication and response system, or (B) an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

During the inspection, on May 8th 2013, the inspector noted that the main exit door, at the front of the home, which is accessible to residents and leads to the outside of the home, is not equipped with an audible door alarm.

During the inspection, on May 8th 2013, the inspector noted that the resident accessible door that leads to a stairway, in the service area to the left of the Prescott care unit nurse station, is not equipped with an audible door alarm.

During the inspection, on May 8th and 9th 2013, the inspector noted that resident accessible exit doors, within care units and a service area, that lead to unsecured areas outside of the home that do not preclude exit by a resident, are not equipped with audible door alarms. This pertains specifically to the two exit doors within the Prescott care unit, the exit door within the Osie F. Villeneuve (OFV) care unit, the exit door within the OFV activity room, the exit door within the "A" service area (near the old basement) and the exit door within the Kenyon care unit. It is however noted that opening these doors does trigger the resident–staff communication and response system (which is not the case for the home's front exit door and the door that leads to a stairway in the service area to the left of the Prescott care unit nurse station). Nursing staff receive

notification if an exit door has been opened on their pager phones and sound is emitted from a wall mounted resident-staff communication and response system console in the general vicinity of the door. For example, in the Prescott care unit, the console is in the lounge close to the end of the hallway, in the OFV care unit the console is approximately mid way down the hallway, and in the "A" service area the console is within the tub room near the OFV nurse station (and therefore the sound can not be heard at the exit door). Staff cancel the notification that an exit door has been opened by pressing a button on the side of the console. The resident accessible exit doors referred to above must be equipped with audible door alarms. These door alarms must only allow calls to be cancelled at the point of activation. The point of activation of a door alarm is at the door itself.

Note: The inspector was unable to ascertain if the resident accessible exit door at the end of the Roxborough care unit, and the resident accessible exit door next to Piper's Lounge within the Kenyon/Roxborough area of the home, both of which to outdoor unsecured areas, are equipped with alarms as is required. (133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 31st day of May, 2013

Signature of Inspector / Signature de l'inspecteur : Jessica Lapensée

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

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