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

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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
Sep 11, 2015	2015_346133_0035	O-002309-15	Critical Incident System

Licensee/Titulaire de permis

CITY OF OTTAWA
Long Term Care Branch 275 Perrier Avenue OTTAWA ON K1L 5C6

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

PETER D. CLARK CENTRE
9 MERIDIAN PLACE OTTAWA ON K2G 6P8

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): (on site) September 2nd, 3rd, 2015

During the course of the inspection, the inspector(s) spoke with the acting Administrator and the Facility Operator. The inspector spoke with a Strategic Initiative Planning Officer with the City of Ottawa on the telephone, and communicated via email with a Security Adviser with the City of Ottawa.

During the course of the inspection, the inspector reviewed the home's written emergency plans.

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)**
- **0 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. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (2) Every licensee of a long-term care home shall ensure that the emergency plans for the home are in writing. O. Reg. 79/10, s. 230 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 230 (2) in that the licensee has failed to ensure that all of the emergency plans for the home are in writing.

As per O. Reg. 79/10, s. 230 (4) 1. viii, the licensee shall ensure that the emergency plans provide for dealing with loss of one or more essential services.

As per O. Reg. 79/10, s. 19 (1) (c), essential services include safety and emergency equipment. The security system in place on resident accessible doors that lead to the outside of the home, and on residents accessible doors that lead to stairways, which includes both locks and alarms, is considered to be resident safety equipment.

On June 12th, 2015, the home's acting Administrator submitted a Critical Incident Report (CIR) to the Ministry of Health and Long Term Care to inform that beginning on June 11th, 2015, the home had been experiencing a failure with the City of Ottawa Corporate Security's monitoring system of the exit and stairwell doors in both buildings, and that there was no audible sound and the staff pagers were not getting notice when the doors were left open for more than 30 seconds.

On September 2nd, 2015, the inspector began a Critical Incident System inspection at the home, related to the matter described above. The home's acting Administrator and Facility Operator (FO) met and discussed the CIR. The inspector was informed that the failure had affected all of the City of Ottawa long term care (ltc) homes. The inspector was informed that for a short period, on the second day of the outage, the door locking system also went down. The Administrator and the FO speculated that the alarm outage lasted for five days, but advised the inspector to contact the City of Ottawa Corporate Security department to confirm the exact time span, as they were not certain about it. The inspector enquired if the response to the outage had been guided by an emergency plan. The inspector was told that there was no written emergency plan that provided for dealing with the loss of the door security system. The inspector was told that the acting Administrator and FO felt the situation was potentially serious and that they specifically requested that the City of Ottawa Corporate Security department provide a security guard for every affected door, in both buildings.

On September 2nd, 2015, the acting Administrator provided the inspector with the home's emergency measures manual, which contained all of the home's emergency plans, for review. The inspector noted that code grey included several plans that provide for dealing with the loss of essential services, such as the loss of elevators, the loss of the resident-staff communication and response system and the loss of the heating system. There were no written plans for dealing with the loss of safety and emergency equipment, which includes the door security system. The acting Administrator informed that the home's emergency plans are not developed by the home's staff. The plans are

received, reviewed and implemented by the ltc homes' Emergency Services Committee. This committee is comprised of management staff from each of the four City of Ottawa ltc homes.

On September 4th, 2015, the inspector spoke with a Strategic Initiative Project Officer (SIPO) with the City of Ottawa Community and Social Services Department, staff # S101, who was involved with the development of emergency plans for the City's ltc homes. The inspector explained to the SIPO that while at Peter D. Clark, she had found emergency plans that provided for dealing with some, but not all, of the essential services outlined in O. Reg. 79/10, s. 19 (1) (c). The inspector asked how it had been determined what would require an emergency plan, for the ltc homes. The SIPO indicated that at some point in the past, someone had provided her with a list of what would require an emergency plan for the ltc homes, but she could not recall exactly who had done so, or when.

On September 9th, 2015, via email communication with a security Adviser, staff # S100, with the Emergency and Protective Services Department of the City of Ottawa, the inspector was made aware that door security system had malfunctioned at Peter D. Clark Centre on June 11th and 12th. The security Adviser wrote that "guards were kept on site until June 15th as we were concerned about the risk of system instabilities while we were troubleshooting software issues". As well, the Security Adviser wrote that on June 11th and 12th "doors would have been locking/unlocking and alarms would have been functioning intermittently, hence the precautionary measure of assigning guards to the sites". [s. 230. (2)]

Issued on this 11th day of September, 2015

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

Original report signed by the inspector.