Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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 Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Aug 18, 2016;	2016_289550_0015 (A2)	008281-16	Resident Quality Inspection

Licensee/Titulaire de permis

UNITED COUNTIES OF PRESCOTT AND RUSSELL
59 Court Street Box 304 L'Orignal ON K0B 1K0

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

RESIDENCE PRESCOTT et RUSSELL
1020, Cartier Boulevard HAWKESBURY ON K6A 1W7

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

JOELLE TAILLEFER (211) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance date extended for CO: #001 s. 8. (3) to October 31, 2016

Issued on this 18 day of August 2016 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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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
Aug 10, 2016	2016_289550_0015 (A1)	008281-16	Resident Quality Inspection
Aug 18, 2016;	2016_289550_0015 (A2)	008281-16	Resident Quality Inspection

Licensee/Titulaire de permis

UNITED COUNTIES OF PRESCOTT AND RUSSELL
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1020, Cartier Boulevard HAWKESBURY ON K6A 1W7

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

JOELLE TAILLEFER (211)
ANGELE ALBERT-RITCHIE (545)
JOANNE HENRIE (550)
MELANIE SARRAZIN (592)
JOANNE HENRIE (550) - (A1)

JOELLE TAILLEFER (211) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): April 18, 19, 20, 21, 22, 25, 26, 27, 28 and 29, 2016.

This inspection also included 2 complaints under log 005255-16 and 002306-16 related to staffing issues, a complaint under log 021744-15 regarding continence care and a critical incident report under log 013065-15 related to allegations of resident to resident sexual abuse.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, the Director of Care (DOC), the Food Service Supervisor/Recreation and Programs Manager, the Physiotherapist, the MDS/RAI Coordinator, the Clinical Care Coordinator, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), the Program Technician, Food Service Workers, housekeeping aides, laundry aides, Maintenance staffs, Receptionist, Administrator's Assistant, families and residents.

In addition, the inspectors reviewed resident health care records, policies related to staffing, restraints, lost items, staffing schedules, resident council minutes and family council minutes. Inspectors observed resident care and services, staff and resident interaction, and meal services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Safe and Secure Home

Sufficient Staffing

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

12 WN(s)
5 VPC(s)
2 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 LTCHA, 2007, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was at least one registered nurse (RN), who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times, except as provided for in the regulations.

Residence Prescott et Russell is a 146 bed Long-Term Care home.

Review of the Residence Prescott and Russell's RN staffing schedule for the period from January 3, 2016 to February 27, 2016 and interview with Nursing Care Supervisor indicated the following shifts were identified as not having an RN present in the home:

January 5, 2016, on evening shift from 1500 to 2300 hours,
January 21, 28, 2016, on night shift from 2300 to 0700 hours,
February 5, 8, 9, 2016, on night shift from 2300 to 0700 hours,
February 27, 2016, on day from 0700 to 1500 hours and night shift from 2300 to 0700 hours.

Ontario Regulation 79/10 section 45 (2) indicates that "emergency" means an unforeseen situation of a serious nature that prevents a Registered Nurse from getting to the Long-Term care home.

Interview with Unit clerk #147 revealed that none of the absences were due to an emergency situation. The above shifts were related to RN's vacation, week-end off or sick call that were called in over 13 hours before the start of the shift.

Interview with the Nursing Care Supervisor revealed an RN was not present in the home during the above missing shifts. She further indicated to Inspector #211 that the above shifts were not considered emergencies related to an unforeseen situation.

The scope and severity of this non-compliance was reviewed. All of the identified shifts were mostly night shifts. The absence of a Registered Nurse, who is familiar with the residents that reside in the long term care home, potentially poses a risk to resident safety and affects every resident living in the home.

This finding of non-compliance is related to two complaints Log # 002306-16 and Log #005255-16 related to staffing issues. [s. 8. (3)]

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 001

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; 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).

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

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).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rule is complied with: All 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 to, were equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation and, was connected to an audio visual enunciator that was connected to the nurses' station nearest to the door and has a manual reset switch at each door, such as the home's main door.

The home's main exit/entrance doors, facing Cartier Street and the parking lot, were within the lobby area. The inner door was kept closed and locked, and the receptionist let residents and visitors out by pressing a button under the desk at the reception area. An access code identified by the keypad by the main door was visible and used by residents and visitors when the receptionist was not available, for example from 1900 and 0830 Monday to Friday and between 1900 and 1100 Saturday and Sunday. The inner door led into a vestibule, and the outer vestibule door led to the outside. The outer vestibule door was kept closed and unlocked. A green button was observed in the vestibule with a sign indicating to "press on green button to unlock the door".

The point of activation of the alarm in place for the home's main exit is the inner door (main door).

On April 25, 2016, Inspector #545 entered the access code in the keypad by the main entrance door, after 54 seconds the alarm was sounded and within a few seconds it stopped. Receptionist #135, seated at the reception desk near the main entrance door indicated to the inspector that she had cancelled the alarm by pressing a button available under the reception desk. She further indicated that this button unlocked the door, as well as cancelled the alarm. She indicated that the alarm could also be cancelled at the point of activation by entering the same access code used to exit the door. The Inspector alarmed the door a second time, and was unable to cancel the alarm at the point of activation. Maintenance Staff #102 arrived at the main door and attempted to cancel the alarm at the point of activation by entering the access code, but was unable to. The door remained locked, and the alarm continued sounding. When a visitor, in the vestibule pressed the green button to unlock the door to enter the home, the main entrance door unlocked and the alarm was then cancelled. It was determined that at the time of observation, apart from using the button at the reception desk, in order to cancel the main door alarm, staff would have to exit the building through another door, and then enter into the vestibule and press the green button to cancel the alarm and unlock the door.

Receptionist #135 indicated to Inspector #545 that she cancelled the main door alarm several times daily using the button located under the reception desk, added that she had tried to use the access code at the point of activation in the past and had noticed that it did not work. She further indicated that when she left the receptionist desk throughout the day, no one covered in her absence.

Maintenance Staff #102 later indicated to the Inspector that the main door alarm was not connected to the resident-staff communication and response system, nor 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. He indicated that he believed that the sound was heard everywhere on the main floor, as well as the second floor. The alarm was sounded once again, and the maintenance staff and Inspector left the main entrance area to go towards the nearest nurses' station located by the physiotherapy room, and near the Spence Unit, and barely heard the sound of the alarm. Inspector #592 who was on the second floor on Cartier did not hear the main door alarm.

The Administrator explained that the home had not considered the main door as a door leading to the outdoors, because it did not lead immediately and directly to the outdoors, due to the vestibule between the inner and outer doors. As a result, the main door's alarm had not been connected to the resident-staff communication and response system nor to an audio visual enunciator that was connected to the nurses' station nearest to the door with a manual reset switch at the door. She further indicated that she was not aware that the main door was not equipped with an alarm that allowed calls to be cancelled only at the point of activation, however was aware that the receptionist cancelled the alarm using a button at the receptionist desk.

The licensee has failed to ensure that all doors in the home, particularly the basement level doors leading to the outside of the home were kept closed and locked, equipped with a door access control system that was kept on at all times, and equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation and was connected to the resident-staff communication and system, or was connected to an audio visual enunciator that was connected to the nurses' station nearest to the door and had a manual reset switch at each door, as residents had access to this non-residential area of the home.

Inspector #545 was informed that the basement level was a non-residential area of the home, and could only be accessed via an access code entered on a keypad available in the elevator. The inspector was also informed that residents were not provided with the access code and/or a swipe key.

On April 20, 2016 Inspector #592 and #545 reviewed elevator #1: Inspector #592 was on the third floor and Inspector #545 was in the basement. Inspector #545 signaled elevator #1 from the basement by pressing the arrow pointing up button. Inspector #592 was waiting in elevator #1, on the third floor; resident #031 entered the elevator and pressed the first floor button. The elevator descended to the first floor, and the resident exited the elevator and a family member entered the elevator and indicated he/she was going to the third floor. After pressing the third floor button, the button was lit with a red light; the basement button was not lit to indicate it was on route to the basement. The elevator descended to the basement, a non-residential area of the home, and the doors opened. Inspector #545 observed this non-residential area of the home, and noted that there were four unlocked doors leading to the exterior, used by staff to enter and exit from the home.

Resident #036 indicated to Inspector #545 that he/she regularly used either elevator to go from the third to the first floor and on many occasions he/she ended up in the basement without having signaled it. He/she further indicated that once in the basement, the elevator door opened to the basement, and on occasion with no person outside the elevator, thus providing access to a restricted area.

Resident #042 indicated to Inspector #545 that he/she used either elevator to go from the third floor to the main floors for meals. The resident indicated that on many occasions, the elevators have descended to the basement without having signaled it, added that he/she was told by maintenance staff that anyone signaling the elevator from the basement was given priority. Resident #042 further indicated that on many occasions, upon elevator doors opening in the basement, no person was outside the elevator, thus providing access to a restricted area. He/she indicated to the inspector that he/she knew the access code of the elevator to the basement, added that even if it was not written, it was the same code as other exit doors in the home, where a sticky with the code was posted just

below the keypad. The resident further indicated that he/she had been in the basement on his/her own, mainly to speak with the laundry staff re: issues with clothes.

In the basement level the following doors leading to the outside of the home were closed but were not locked, they were not equipped with a door access control system that was kept on at all times, and they were not equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation and connected to the resident-staff communication system, or was not connected to an audio visual enunciator that was connected to the nurses' station nearest to the door and had a manual reset switch at each door, as residents had access to this non-residential area of the home:

(a) Door leading to a stairwell which then led to a set of double exterior doors on the main floor. Note that a red sign indicating "this door is equipped with an alarm, use in case of emergency only" was posted on the double-dooors, but when left opened by the Inspector on April 21, 2016 at 1547, no audible door alarm was activated. This exterior door led to the parking lot and Cartier Street, a busy street. Once outside, the inspector was unable to re-enter, unless using a swipe key.

(b) Door #051 was located off the main basement hallway and leading into the Maintenance Staff area, which then led to a stairwell and to an exterior door on the main floor. This exterior door led to the home's gazebo and a ravine, as well as the parking lot and Cartier Street, a busy street. Once outside the inspector was unable to re-enter via the same door as it was locked.

(c) Exit Door #14 was located by the staff room via an unlocked closed door. This exterior door led to a parking lot and Spence Street, a busy street. Once outside, the inspector was not able to re- enter as the door was locked, unless using a swipe key.

(d) Exit Double-doors #19 was located at the far end of the basement near the shipping and receiving dock. This exterior door led to a parking lot and Spence Street, a busy street. Once outside, the inspector was not able to re-enter as the door was locked, unless pressing a green button by the door alerting staff.

During an interview with Maintenance Staff #129, who was one of the most senior staff in the maintenance department, he indicated that all four doors identified above, particularly the basement level doors leading to the outside of the home were kept closed but not locked between the hours of 2000 and 0500. He further indicated that they were equipped with a door access control system, but that it was not kept on at all times; only between the hours of 2000 and 0500. Maintenance Staff #129 activated all door alarms, in presence of Administrator and Inspector by entering an access code in a console located at the nurse's/PSW station, an audible door alarm was heard. To cancel the alarm, the maintenance staff re-entered the same access code into the console at the nurse's/PSW station. He confirmed that those doors were connected to an audio visual enunciator that was connected to the nurses' station nearest to the door, but the doors were not equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation, nor were equipped with a manual reset switch at each door.

The lack of elevator security and access to unlocked and unalarmed doors presents a potential risk to residents of the home. These doors in the basement do lock from the outside, adding another level of risk as residents would have access to go out of these four doors however the resident would not be

able to return back inside the home. (545)

2. The licensee failed to ensure that all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff.

On April 18, 2016 at 0939, during the initial tour, Inspector #545 observed the home's physiotherapy room (#1114) located on the main floor near the elevators and across from the cafeteria (large dining room) with the door opened and unlocked. There were no residents or staff in the room at the time of the observation. The inspector observed on a counter, a hydrocollator steam pack machine in use. The exterior of the machine was very hot to touch and the interior of the machine was filled with very hot water and two hot packs. Three exercise bicycles were observed as well as parallel bars.

During an interview with the Physiotherapy Assistant (PTA), he indicated that the door to the physiotherapy room should be closed and locked at all times when not in use due to potential risks of injury to residents, such as the hydrocollator steam pack machine which is always in use, with temperature of water at 160 degree Fahrenheit (or 71 degree Celsius) when taken with the home's thermometer in presence of the inspector. The PTA further indicated that the equipment in the room were also potential risks of injury to residents, added that when not in use, the door was always closed and locked.

The FSS and Acting ESS on April 25, 2016 indicated that the physiotherapy room was equipped with a lock to restrict unsupervised access to this room by residents and should be closed and locked when not in use.

The Food Service Supervisor/Acting Environmental Services Supervisor (ESS) indicated that the basement was a non-residential area, and that doors leading to this area, were equipped with locks to restrict unsupervised access by residents.

Maintenance Staff #102 and #129 indicated that the basement was a non-residential area, accessed by staff with a code in the elevator and/or stairs. They indicated that residents did access the basement, mostly to go to the laundry room. They both indicated that the door to the shop was kept locked to prevent tools from disappearing, but also to restrict unsupervised access by residents when it was not being supervised by staff. Maintenance Staff #129 indicated that many electrical tools were easily accessible in the shop and could pose a risk of injury to residents.

On April 21, 2016 at 1419 Inspector #545 observed the basement Maintenance Shop door (#055) open and unlocked. There was no staff in the front part of the shop where electrical tools were easily accessible. There was no one in the office, in the back of the shop, therefore the door leading to non-residential area was not locked or supervised by staff.

The Administrator and Food Service Supervisor covering for the Acting ESS indicated to Inspector #545 that they were aware that the residents could inadvertently arrive in the basement, a non-residential area, without having entered the access code in the elevator, therefore any doors unlocked when not being supervised by staff, would not restrict unsupervised access by residents, such as the maintenance shop. (545)

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each residents that sets out,
(a) The planned of care for the resident;
(b) The goals the care is intended to achieve; and
(c) Clear directions to staff and others who provide direct care to the resident.

Review of the progress notes indicated a continence procedure was placed for resident #023 on an identified date related to continence problems. The continence procedure was stopped on an identified date and replaced three days later.

Review of the physician's email on an identified date and signed by the physician two days later indicated to keep the same continence intervention.

Review of the physician's email on one month later and signed by the physician four days later indicated to start the continence procedure for resident #023.

Review of the written plan of care on an identified date for resident #023, and interviews with RPN #114 and PSW #115, revealed that it did not indicate that the resident required a specific intervention for continence care.

Interview with RPN #114 who indicated that the update of the written care plan for the residents' is written by hand in the current plan of care that is left in a binder at the nursing station. The hand written update will be added to the next written plan of care during the quarterly revision. The RPN revealed that the written plan of care in the binder was not updated by hand related to the resident's intervention for continence.

The DOC confirmed that the resident's written care plan did not set out the plan, the goals and the intervention related to the intervention for continence in resident #023's written plan of care. [s. 6. (1)]

2. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Inspector #550 observed PSW staff #133 at lunchtime encouraging resident #006 to feed himself/herself. The resident would take a spoonful in his/her mouth and put the spoon on the table afterwards. The PSW had to cue the resident between each spoonful to eat as the resident would not eat on his/her own. After taking three spoonfuls, the resident would not eat on his/her own even when cued by the PSW. The resident was sitting in the chair with his/her eyes closed. The PSW had to physically feed the resident the rest of the meal.

During an interview, PSWs #132 and #133 both indicated to the inspector that resident #006 now requires to be fed most of the meal by staff. They indicated a few months ago he/she was able to feed himself/herself when cued by staff but now he/she no longer is able to because of the progression of cognitive impairment. The resident will take a few spoonfuls on his/her own when guided by staff but the rest of the meal needs to be fed to the resident as he/she would not eat.

Inspector reviewed the plan of care for resident #006 dated on an identified date and noted in the documentation that the resident requires supervision during meals and staff need to initiate the task.

As evidenced above, the plan of care for resident #006 was not reviewed and revised when his/her care needs changed. [s. 6. (10) (b)]

3. On an identified date the home received a complaint from a family member regarding the continence care of resident #052. Resident #052's spouse complained that when he/she requested that staff on the evening shift bring his/her spouse to the toilet, he/she was told by the PSW that the resident was to void in the incontinence product and that they would change him/her in bed after.

A review of resident #052's health care records indicated that the resident was diagnosed with several medical conditions, including cognitive impairment and other medical health issues. The resident's plan of care for a specific month indicated under elimination, to bring resident to the bathroom as per his/her request with the assistance of two staff members. The resident's plan of care further indicated under transfer that resident is transferred with the assistance of two staff members and to use the specified equipment as needed.

A review of the complaint/comments report provided by the nurse supervisor indicated that upon the home's investigation, the evening staff members were no longer bringing resident #052 to the toilet due to general weakness and because the resident did not have adaptable clothes to facilitate the resident's transfer on the toilet. The report further indicated that the practice of not bringing resident #052 to the toilet was part of the resident's routine for more than a month on evenings.

In an interview with the nurse supervisor who did the follow-up on the complaint, she told Inspector #592 that following the home investigation, she was told by evening staff members that they had taken upon themselves the decision to not bring resident #052 to the toilet due to weakness and to

the fact that the resident did not have adapted clothes. She indicated that since the incident occurred, the spouse brought adaptable clothes for the resident and that staff members were bringing resident #052 to the toilet as per his/her request.

As such, resident #052 was not reassessed and the plan of care reviewed when his/her care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written plan of care for resident #023 is revised to include the continence care with goals and interventions, resident #052 is provided with continence care as specified in the plan of care and resident #006's plan of care reflects his/her needs regarding eating, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system was available in every area accessible by residents.

During the initial tour on April 19, 2016, Inspector #545 observed the home's Bistro (room 1138) located on the main floor across from the cafeteria (large dining room), where 12 residents and two staff were engaged in an exercise class. The inspector could not locate a resident-staff communication and response system.

Activity Aide #124 indicated that there was no resident-staff communication and response system in the Bistro. She confirmed that the Bistro was a common area for residents where a variety of activities occurred daily.

The Food Services Supervisor (FSS) covering for the Acting Environmental Services Supervisor (ESS) on April 22, 2016 indicated to Inspector #545 that there was no resident-staff communication and response system available in the Bistro; an area accessible by residents.
She further indicated that if there was an emergency, staff would use the phone located in the office behind the counter, added that residents and visitors would not be expected to know that the phone could be used in case of emergencies. [s. 17. (1) (e)]

2. The license failed to ensure that the home was equipped with a resident-staff communication and response system that, in the case of a system that used sound to alert staff, was properly calibrated so that the level of sound was audible to staff.

The home used a resident-staff communication and response system that used sound to alert staff, as well as a visual indicator system with various colours of flashing and solid lights. An annunciator was located centrally on each floor; at the PSW station across from the nursing station on the first floor and by the elevators and nursing stations on the second and third floors.

During a tour of the first floor on April 18, 2016, Inspector #545 observed in the following common areas on the first floor, a resident-staff communication and response system where the level of sound was not audible to staff when activated by the Inspector:
-Physiotherapy room
-Large dining room (cafeteria) and small dining room
-Resident washroom by the large dining room

In the physiotherapy room, Physio Assistant (PTA) #105 indicated that the resident-staff communication and response system was not functional, however when activated by Inspector #545, a small button instantly illuminated at the point of care, and one was illuminated in the hallway outside the physiotherapy room. The level of sound was not audible from inside and outside the physiotherapy room. Later, Physiotherapist #110 indicated to the Inspector that he was not aware of any resident-staff communication system in the physiotherapy room, and in an emergency he would use the phone available in the physiotherapy room.

In the large dining room, Dietary Aide #106 indicated that the resident-staff communication and response system in the large dining room (cafeteria) had never been functional and from her knowledge was never used by staff. Upon activating it, a small button instantly illuminated at the point of activation, and one was illuminated at the end of the hallway. The level of sound was not audible from inside and outside the cafeteria.

During an interview with the acting Environmental Services Supervisor (ESS) she confirmed that the home's resident-staff communication and response system used sound to alert staff, however it was not properly calibrated so that the level of sound was audible to staff. [s. 17. (1) (g)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all areas accessible by residents are equipped with a resident-staff communication and response system and that the system is properly calibrated so that the level of the sound is audible to staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device. Specifically failed to comply with the following:

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

5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg.79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

On April 19, 20, 21 and 22, 2016, resident #040 was observed up in a wheelchair with a specific type of lap belt.

In a review of the resident health care records, the resident no longer ambulates and was assessed as needing a lap belt when in his/her wheelchair to prevent resident from falling.

On April 21, 2016, during an interview with PSW #109, she confirmed with Inspector #592 that resident #040 is up in the wheelchair daily with a specific type of lap belt attached at all times. She further told Inspector #592 that otherwise resident would try to get out of his/her chair and he/she is not able to walk. She indicated to Inspector #592 that the resident needs to be checked every two hours to ensure that the restraint is well applied. She further indicated that PSWs were to document when the restraint is applied to the resident, and the assessment, reassessment and monitoring conducted, when the device is released and repositioning of the resident and then finally the removal of the device. PSW #109 indicated that the staffs are to document these areas by putting a check mark in the specified areas on the flow sheet at the nursing station.

On April 21, 2016, during an interview with PSW #108, she told Inspector #592 that there was no indication for the frequency of the monitoring for residents who were using a restraint device. She told Inspector #592 that residents were checked during the day and that the staff was always around to make sure that the residents were safe. Staffs were to document when the restraint was applied and when the restraint was removed on a flow sheet at the nursing station.

During an interview with RPN #107, she told Inspector #592 that resident #040 was using a specific type of lap belt daily to maintain his/her position in the wheelchair, otherwise, resident was bending forward often and at risk for falls. RPN #107 showed inspector #592 the restraint form for the monitoring of residents located at the nursing station and told inspector that there was no specific hours to write the application and the removal of the restraint but that the staff need to document by putting a check mark in the specified areas on the flow sheet when the restraint is applied, when the resident is repositioned and when the restraint is release or removed. She further told Inspector #592 that the expectation is that all residents should be monitored every 2 hours.

Resident #040's plan of care indicated the type of restraint used and the monitoring of resident on each shift, but it does not provide clear guidelines for reassessment, nor does it indicate when the restraint is to be released and the resident repositioned, or the frequency of such release and repositioning.

Upon reviewing the documentation on the restraint flowsheet (Formulaire de verification quotidienne des contentions) used by the PSWs, Inspector #592 observed numerous omissions in the documentation for one month for Resident #040. Documentation as follows for a specific period for resident #040:

-it was noted that resident #040 was monitored every hour on 5 out of 19 day shifts,
-it was noted that resident #040 was monitored every hour on 7 out of 19 evening shifts.
-it was noted that the removal of the restraint every 2 hours while awake for resident #040 was

documented on 6 out of 19 day shifts,
-it was noted that the removal of the restraint every 2 hours while awake for resident #040 was documented on 6 out of 19 evening shifts,
-it was noted that the repositioning every 2 hours while awake for resident #040 was documented on 6 out of 19 day shifts,
-it was noted that the repositioning every 2 hours while awake for resident #040 was documented on 7 out of 19 evening shifts.
-the time of the restraint application was documented on 6 out of 19 days and that the removal of the device, including the time of removal was documented on 3 out of 19 days and,
-the resident's assessment/reassessment and monitoring including the resident's response was documented on 5 out of 19 days and 7 out of 19 evening shifts.

2. On April 19, 20, 21 and 22, 2016, Inspector #592 observed Resident #033 to have a restraint seat belt while seated in his/her wheelchair.

Resident #033's health care records indicated the resident was diagnosed with cognitive impairment and other medical health issues. It indicated that the resident was no longer ambulating and was assessed as requiring a specific type of lap belt when he/she is in the wheelchair to prevent the resident from falling.

On April 22, 2016, Inspector #592, interviewed resident #033 who confirmed with Inspector #592 that he/she was unable to release the device and that the device was in place when he/she was up in the wheelchair. Resident #033, told Inspector #592 that he/she was falling often by attempting to stand up on his/her own and that he/she was staying in the chair all day as per his/her request.

On April 25, 2016, during an interview with PSWs #122 and #123, they both told Inspector #592 that resident #033 is up in the wheelchair daily requiring a specific type of lap belt attached at all times, otherwise the resident would try to get out of his/her chair and would fall. They both told Inspector #592 that the resident is transferred to the wheelchair before breakfast and he/she spends all his/her time in the wheelchair during the days.

Resident #033's plan of care indicated the type of restraint used but it did not provide clear guidelines for the monitoring of the resident and the reassessment, and it did not indicate when the restraint was to be released and the resident repositioned, or the frequency of such release and repositioning.

Upon reviewing the documentation on the restraint flowsheet (Formulaire de verification quotidienne des contentions) used by the PSWs, Inspector #592 observed numerous omissions in the documentation for a specific month for Resident #033. Documentation as follows for a specific period for resident #033:

-it was noted that the resident was monitored every hour 12 out of 19 day shifts,
-it was noted that the resident was monitored every hour 7 out of 19 evening shifts,
-it was noted that the removal of the restraint every 2 hours while awake for resident #033 was documented 13 out of 19 day shifts,
-it was noted that the removal of the restraint every 2 hours while awake for resident #033 was documented 7 out of 19 evening shifts,

-it was noted that the repositioning every 2 hours while awake for resident #033 was documented 8 out of 19 day shifts,
-it was noted that the repositioning every 2 hours while awake for resident #033 was documented 8 out of 19 evening shifts,
-the time of the restraint application was documented 6 out of 19 days and that the removal of the device, including the time of removal was documented 3 out of 19 days and,
-the resident's assessment/reassessment and monitoring including the resident's response was documented 12 out of 19 days and 7 out of 19 evenings.

3. On April 19 and 27, 2016, resident #010 was observed up in his/her wheelchair with a restraint seat belt.

In a review of the RAI MDS assessment dated a specific date, under section P4, devices and restraints, resident #010 was identified using side rails and no other type of physical devices was identified for the resident.

A review of the resident's plan of care indicated the resident was no longer ambulating and was assessed as requiring a specific type of lap belt when in the wheelchair to prevent the resident from falling.

On an identified date, in an interview with the resident's spouse, he/she told Inspector #592 that he/she gave the home consent to have his/her spouse use the specific type of lap belt due to the resident's tendency to slip out of the wheelchair and trying to get out on his/her own. He/she further told Inspector #592 that his/her spouse sustained an injury and since then alternatives were tried but the last resource was the use of the specific type of lap belt. He/she further told Inspector #592 that his/her spouse had to keep the restraint device in place when he/she was up in the wheelchair at all times. He/she told Inspector #592 that his/her spouse's routine was to be put in the wheelchair before breakfast where he/she would stay until the afternoon when staffs were putting him/her to bed. He/she then added that staffs were getting his/her spouse up in the afternoon and that he/she would be brought to the dining room for dinner but unsure of the time when his/her spouse was put to bed.

On an identified date in an interview with PSW #140, she confirmed with Inspector #592 that resident #010 is up in the wheelchair daily requiring a specific type of lap belt attached at all times, otherwise the resident would try to get out of the chair and would fall. She further told Inspector #592 that the resident was transferred to the wheelchair before breakfast and then stayed in the chair until the afternoon. She further told Inspector #592 that when she finishes her shift, the evening staff were getting the resident up in the chair and then brought him/her to the dining room for dinner. She indicated the resident was monitored every two hours and that staff were expected to fill out a restraint section in their computer software and as well in a binder located at the nurse's station. Upon a review of the "Formulaire de verification quotidienne des contentions " with PSW #140, Inspector #592 observed numerous omissions in the documentation. PSW #140 confirmed that the time of the documentation of the application of the lap belt on days was omitted at times due to the lack of time.

On April 28, 2016, in an interview with RN #142, she confirmed with Inspector #592 that resident

#010 was usually put to bed in the afternoon depending on the activities offered by the home.

The resident was up in the wheelchair before breakfast and then put to bed after 1900. She further confirmed that the resident required a specific type of lap belt attached at all times when he/she is up in the wheelchair.

Resident #010's plan of care indicated the type of restraint used, but did not provide clear guidelines for the monitoring of resident and the reassessment, nor did it indicate when the restraint was to be released and the resident repositioned, or the frequency of such release and repositioning.

Upon reviewing the documentation on the restraints' flowsheet (Formulaire de verification quotidienne des contentions) used by the PSWs, Inspector #592 observed numerous omissions in the documentation for one month for Resident #010. Documentation as follows for a specific period for resident #010:

-it was noted that the resident was monitored every hour on 4 out of 26 evening shifts,
-it was noted that the removal of the restraint every 2 hours while awake for resident #010 was documented 5 out of 26 evening shifts,
-it was noted that the repositioning every 2 hours while awake for resident #010 was documented 6 out of 26 evening shifts,
-the time of the restraint application was documented 13 out of 26 days and that the removal of the device, including the time of removal was documented 6 out of 26 days and,
-the resident's assessment/reassessment and monitoring including the resident's response was documented on 4 out of 26 evenings.

In an interview with the DOC, she told Inspector #592 that all PSWs and registered staff were aware that they have to document the time of the application of the device, the release, the removal, the monitoring and the response of the resident on the "Formulaire de verification quotidienne des contentions" form. She further told Inspector #592 that staffs have received annual training on the use of the restraint, including the documentation and that one on one monitoring was done with staff members. The DOC reviewed the restraint monitoring documentation with Inspector #592 and confirmed that there were omissions of documentation for resident #040, #033 and #010; the time of the restraint application, the repositioning of the resident, the removal and the release of the lap belt restraint as well as the monitoring of the resident's response to the use of the restraints, therefore she was unable to determine if staff were following the requirements. [s. 110. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every use of a physical device to restrain a resident under section 31 of the act is documented including the person who applied the device and the time of the application, all assessment, reassessment and monitoring, including the resident's response, every release of the device and all repositioning and the removal or discontinuance of the device, including time of removal or discontinuance, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

On April 26, 2016, Inspector #211 observed that the locked medication refrigerator in the nursing station on the third floor contained different kind of insulin and the following foods:
-one container with pasta,
-one container with peeled orange sections and,
-one avocado.

Interview with RPN #107, RPN #114, and DOC confirmed that food should not be stored in the medication refrigerator and only drugs and drug-related supplies should be kept in the medication refrigerator.

On April 26, 2016, Inspector #211 observed a chocolate bar in resident #049's medication bin and resident #050 hearing aids' empty case in the medication cart on the third floor.

Interview with RPN #107 revealed that resident #050's hearing aids were kept inside the case inside the medication cart when the resident was not wearing them.

Interview with the DOC revealed that it is the home's practice to keep residents' hearing aids and eye glasses in a separated segment in the medication cart.

Interview with RPN #107 and DOC confirmed the resident's chocolate bar should not be stored in the medication cart. [s. 129. (1) (a) (i)]

2. The licensee has failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On April 26, 2016, Inspector #211 observed that twelve controlled substances medication blister packs were placed outside of the separate locked area within the last drawer of the lock medication cart.

Interview with RPN #107 revealed that she removed all the controlled substance medication blister packs inside the separate locked area and placed them within the last drawer of the lock medication cart. She forgot to put back all the controlled substance medication blister packs inside the separate locked area within the lock medication cart.

Interview with RPN #107 and DOC confirmed that controlled substances must be kept and stored in a separate locked area within the locked medication cart. [s. 129. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or medication cart that is used exclusively for drugs and drug-related supplies and that controlled substances that are stored in the medication cart are stored in a separate locked area within the medication cart, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On April 26, 2016, Inspector #211 observed the vaccine refrigerator located in an office room of the second floor with the presence of two clerks; Quality Care Program Technician and the Unit Clerk.

Interview with RPN #107 and the Nursing Coordinator revealed the office was occupied by two clerks and the vaccine refrigerator was not stored in an area where it was restricted to persons who may dispense, prescribe or administer the medication. The refrigerator contained one tuberculin Purified protein vial, one Pneumovax 23 vial, two Tetanus and diphtheria vials, three Influvac boxes and three boxes of Fluad vials.

The DOC confirmed where drugs are stored, the area must be restricted to persons who may dispense, prescribe or administer drugs in the home. [s. 130. 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the vaccine refrigerator is stored in an area restricted to persons who may dispense, prescribe or administer drugs in the home and the Administrator, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

Resident #037 resides in a semi-private room. Upon observation of the privacy curtains, Inspector #592 noted that there was a ceiling track system crossing over both resident's bed area. Because of this, the privacy curtains could not close properly, leaving an approximate 4 inch gap opening when the privacy curtains were closed, allowing a visual of the co-resident. Resident #037 told Inspector #592 that when personal care was provided to his/her roommate, he/she had to look in another direction otherwise he/she would be able to see the exposed resident.

Inspector #592 observed that semi-private rooms #370, 378, 371, 374, 375, 311, 371, 325, 321 and 379 had the same room set-up with a ceiling track system crossing over the resident's bed area with the same approximate 4 inch gap between the two privacy curtains.

In an interview with PSW #122, she told inspector #592 that there was a 4 inch gap between the privacy curtains when she provided care to the residents and she left the curtains that way and that there was no process in place to close the gap between the curtains. She further told the inspector that resident #047 on the other unit had requested and received a clothes pin to ensure the curtains were properly closed to ensure his/her privacy but no other resident had made that request. She told Inspector #592 that if a resident would request a clothes pin the home would provide them with one.

In an interview with PSW #131, she told Inspector #592 that the privacy curtains where the ceiling track is crossing over the resident's bed area was leaving a gap, and that she was not aware of any process to close the gap between both curtains to ensure the resident's privacy.

In an interview with resident #047, she told Inspector #592 that she had requested to have a clothes pin to close his/her privacy curtains to ensure his/her privacy and make sure he/she was not exposed to the co-resident. He/she further told Inspector #592 that there was a gap when both curtains were pulled together due to the lift and that he/she was not afforded privacy. He/she indicated that he/she felt more at ease since the clothes pin was put on.

In an interview with resident #048 who resides in a semi-private with a ceiling track system in place, he/she told Inspector #592 that he/she was receiving personal care by the staff members in bed and that he/she felt that he/she was not provided privacy during care due to the presence of a gap between the two privacy curtains. Resident told inspector that he/she would like to have both curtains tied closely together to promote privacy from the roommate.

In an interview with the DOC, she told Inspector #592 that she was not aware that the curtains could not be closed completely where the ceiling track system was used and that no staff members had ever mentioned that there was a problem with resident's privacy. She further told Inspector #592 that all residents should be afforded privacy during their treatment and when caring for them and that the home will put a process in place shortly. [s. 13.]

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the equipment, such as resident #002, #033 and #040's ambulation equipment were kept clean and sanitary.

On April 19 and 20, 2016 Inspector #545 and #592 observed the following ambulation equipment unclean and unsanitary, and again on April 26, 2016, when observed again by Inspector #545, there was no change in status of the equipment:

Resident #002
-the headrest was stained with a large area of white dried material from top to bottom, as well as dried food debris on the seat cushion

Resident #033
-foot rests were observed on the floor under the sink with dried food debris, the frame of the wheelchair, the arm rests and the tubular whole where the footrests were to be inserted were covered with dried food debris, as well as dirt accumulation. The seatbelt was observed with dried white stains

Resident #040
-wheels of wheelchair, seat cushion, frame, right wheelchair break, as well as in the tubular whole where the footrests were to be inserted were covered with dried food debris, as well as dirt accumulation

During an interview with PSW #123, she indicated that it was the responsibility of the night PSWs to clean the ambulation equipment each night, and as per the schedule, two residents' ambulation equipment were cleaned each night on each unit. She further indicated that the evening staff took the ambulation equipment out the residents' rooms, placed them in the hallway, then the night PSW took the equipment to the third floor spa for cleaning. The PSW indicated that the seat covers were removed and placed in the washing machine available in the Spa then proceeded to brush off dirt and food debris using a General Purpose Disinfectant and water with a small brush, which she was unable to locate in the Spa and/or Hazardous Product room. She indicated that it was the responsibility of the PSW to sign the schedule after completing the cleaning.

RPN #138 confirmed that Resident #002's ambulation equipment was unclean and RPN #114 confirmed that Resident #033 and #040's ambulation equipment were uncleaned and unsanitary. They indicated that the ambulation equipment would be scheduled for cleaning today. [s. 15. (2) (a)]

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee of the long-term care home did not ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

During the initial tour of the home on April 18, 2016, Inspector #545 observed that all the required information is posted in the home at the front entrance behind a glass mounted display case locked with a key. There is a note that indicated: "To consult a document, please ask the reception desk".

The Food Service supervisor/programs and activity manager indicated to Inspector #550 the reception's hours of operation are Monday to Friday from 0830 to 1900 and on week-ends from 1000 to 1800. Anyone wanting to access the reports after hours when the reception desk is closed, needs to ask a nurse to unlock the wall glass mounted display case.

As such, the required information posted in the home is not located in an easily accessible location. [s. 79. (1)]

2. The licensee has failed to ensure that the Residents' Bill of Rights was posted in a conspicuous and accessible location in a manner that complies with the requirements, if any, established by the regulations.

According to LTCHA 2007, c.8, s. 79 (3) a. it is a requirement that the Residents' Bill of Rights are posted.

During the initial tour of the home on April 18, 2016, Inspector #545 observed that the Residents' Bill of Rights was posted in the main lobby. She noted that it was the old version with 19 rights that was posted and not the new version with the 27 rights as per the LTCHA 2007, s.3.(1).

On April 21, 2016, Inspector #550 interviewed the acting administrator for that day who was the Food Service Supervisor/Programs and Activity manager. She indicated not being aware there was a revised copy of the Residents' Rights. [s. 79. (3) (a)]

WN #11: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey

In a review of the Residents' Council meeting minutes of February 25, 2016, it was documented that the results of the satisfaction survey had been communicated via a Newsletter delivered to each residents' room. There was no documentation in the minutes to indicate that the survey was made available in order to seek the advice of the Council about the survey.

In a review of the Newsletter (No 1, November 2015), provided by Administrative Assistant (AA) #128, results of the 2015 satisfaction survey were documented. The AA added that the Newsletter had been delivered on each resident's dresser, sometime in November 2015. She further indicated that the results were not made available to the Residents' Council.

During an interview with the President of the Residents' Council, he indicated to the Inspector that the results of the 2015 satisfaction survey were not made available to the Council in order to seek their advice.

The Assistant to the Residents' Council indicated to Inspector #545 that there had been no Residents' Council meetings from September 2015 to January 2016 due to a scabies outbreak in the home. She further indicated that the results of the satisfaction survey were not made available to the Residents' Council in order to seek the advice of the Council about the survey, at the February 25, 2016 Council meeting. [s. 85. (4) (a)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Interview with resident #027 on April 19, 2016, revealed he/she informed a staff from the laundry department that beige colored pants were missing, one month ago.

Interview with the Program and dietary supervisor and interim laundry supervisor on April 22, 2016, revealed she was not aware or informed that resident #027 complained to a member of the laundry staff that beige colored pants were missing.

Interview with laundry staff #103 revealed she was informed one month ago by resident #027 that beige colored pants were missing. A search for the missing pants was completed on the same day to no avail, but she forgot to inform her supervisor.

Interview with the interim laundry supervisor confirmed the laundry staff #103 did not report resident #027's missing pants a month ago and the policy process for missing clothing or articles was not followed.

Review of the home's policy #500. 11 titled"Notification of clothing or articles lost" dated October 2015, indicated if an article is not found, the laundry staff needs to inform the laundry supervisor. The supervisor will complete a follow-up with the resident or the family.

Review of the home's policy #780.02 titled"Complaint or Comments process" dated July 2014, indicated the supervisor will complete and sign the sheet titled"Complaint or Comments Process form"with the person wishing to report a complaint.

The DOC confirmed that the policy indicated that the staff that did not find a resident's missing clothes should inform their supervisor to complete the Complaint and Comments Process form. [s. 89. (1) (a) (iv)]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Issued on this 6 day of May 2016

Issued on this 10 day of August 2016 (A1)

Issued on this 18 day of August 2016 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Ottawa Service Area Office
347 Preston St, Suite 420
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston, bureau 420
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) /
Nom de l'inspecteur (No) :

JOELLE TAILLEFER (211)
ANGELE ALBERT-RITCHIE (545)
JOANNE HENRIE (550)
MELANIE SARRAZIN (592)
JOANNE HENRIE (550) - (A1)

JOELLE TAILLEFER (211) - (A2)

Inspection No. /
No de l'inspection :

2016_289550_0015
2016_289550_0015 (A1)
2016_289550_0015 (A2)

Appeal/Dir# /
Appel/Dir#:

Log No. /
Registre no. :

008281-16
008281-16 (A1)
008281-16 (A2)

Type of Inspection /
Genre d'inspection:

Resident Quality Inspection

Report Date(s) /
Date(s) du Rapport :

Aug 10, 2016 (A1)

Aug 18, 2016 (A2)

Licensee /
Titulaire de permis :

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

UNITED COUNTIES OF PRESCOTT AND RUSSELL
59 Court Street, Box 304, L'Orignal, ON, K0B-1K0

LTC Home / Foyer de SLD :

RESIDENCE PRESCOTT et RUSSELL
1020, Cartier Boulevard, HAWKESBURY, ON, K6A-1W7

Name of Administrator / Nom de l'administratrice ou de l'administrateur :

LOUISE LALONDE

To UNITED COUNTIES OF PRESCOTT AND RUSSELL, 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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that at least one Registered Nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

This plan shall include all recruiting and retention strategies and the home's staffing plan to address the backup coverage for managing absenteeism for Registered Nurses to ensure that there is a Registered nurse on site at all times.

This plan must be submitted in writing by May 19, 2016 to:
Joelle Taillefer LTCH Inspector by fax :613-569-9670

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

Grounds / Motifs :

1. The licensee has failed to ensure that there was at least one registered nurse (RN), who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times, except as provided for in the regulations.

Residence Prescott et Russell is a 146 bed Long-Term Care home.

Review of the Residence Prescott and Russell's RN staffing schedule for the period from January 3, 2016 to February 27, 2016 and interview with Nursing Care Supervisor indicated the following shifts were identified as not having an RN present in the home:

January 5, 2016, on evening shift from 1500 to 2300 hours,
January 21, 28, 2016, on night shift from 2300 to 0700 hours,
February 5, 8, 9, 2016, on night shift from 2300 to 0700 hours,
February 27, 2016, on day from 0700 to 1500 hours and night shift from 2300 to 0700 hours.

Ontario Regulation 79/10 section 45 (2) indicates that "emergency" means an unforeseen situation of a serious nature that prevents a Registered Nurse from getting to the Long-Term care home.

Interview with Unit clerk #147 revealed that none of the absences were due to an emergency situation. The above shifts were related to RN's vacation, week-end off or sick call that were called in over 13 hours before the start of the shift.

Interview with the Nursing Care Supervisor revealed an RN was not present in the home during the above missing shifts. She further indicated to Inspector #211 that the above shifts were not considered emergencies related to an unforeseen situation.

The scope and severity of this non-compliance was reviewed. All of the identified shifts were mostly night shifts. The absence of a Registered Nurse, who is familiar with the residents that reside in the long term care home, potentially poses a risk to resident safety and affects every resident living in the home.

This finding of non-compliance is related to two complaints Log # 002306-16 and Log #005255- 16 related to staffing issues. [s. 8. (3)]

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

Aug 29, 2016
Oct 31, 2016(A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

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

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

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

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

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

Order / Ordre :

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

The licensee shall ensure that:

1. All resident accessible doors leading to the outside of the home are to be kept closed and locked, equipped with a door access control system that is kept on at all times, and equipped with an audible door alarm as prescribed.

2. The main (inner) door of the home is to be connected to the resident-staff communication and response system or to an audio visual enunciator that is connected to the nurses' station nearest to the door with a manual reset switch at the door. The main door is to be equipped with an alarm that allows calls to be canceled only at the point of activation;

3. The door leading to the physiotherapy room is to be kept closed and locked when this area is not immediately supervised in order to restrict resident access to this non-residential area.

Grounds / Motifs :

1. The licensee failed to ensure that the following rule is complied with: All 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 to, were equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation and, was connected to an audio visual enunciator that was connected to the nurses' station nearest to the door and has a manual reset switch at each door, such as the home's main door.

The home's main exit/entrance doors, facing Cartier Street and the parking lot, were within the lobby area. The inner door was kept closed and locked, and the receptionist let residents and visitors out by pressing a button under the desk at the reception area. An access code identified by the keypad by the main door was visible and used by residents and visitors when the receptionist was not available, for example from 1900 and 0830 Monday to Friday and between 1900 and 1100 Saturday and Sunday. The inner door led into a vestibule, and the outer vestibule door led to the outside. The outer vestibule door was kept closed and unlocked. A green button was observed in the vestibule with a sign indicating to "press on green button to unlock the door".

The point of activation of the alarm in place for the home's main exit is the inner door (main door).

On April 25, 2016, Inspector #545 entered the access code in the keypad by the main entrance door, after 54 seconds the alarm was sounded and within a few seconds it stopped. Receptionist #135, seated at the reception desk near the main entrance door indicated to the inspector that she had cancelled the alarm by pressing a button available under the reception desk. She further indicated that this button unlocked the door, as well as cancelled the alarm. She indicated that the alarm could also be cancelled at the point of activation by entering the same access code used to exit the door. The Inspector alarmed the door a second time, and was unable to cancel the alarm at the point of activation. Maintenance Staff #102 arrived at the main door and attempted to cancel

the alarm at the point of activation by entering the access code, but was unable to. The door remained locked, and the alarm continued sounding. When a visitor, in the vestibule pressed the green button to unlock the door to enter the home, the main entrance door unlocked and the alarm was then cancelled. It was determined that at the time of observation, apart from using the button at the reception desk, in order to cancel the main door alarm, staff would have to exit the building through another door, and then enter into the vestibule and press the green button to cancel the alarm and unlock the door.

Receptionist #135 indicated to Inspector #545 that she cancelled the main door alarm several times daily using the button located under the reception desk, added that she had tried to use the access code at the point of activation in the past and had noticed that it did not work. She further indicated that when she left the receptionist desk throughout the day, no one covered in her absence.

Maintenance Staff #102 later indicated to the Inspector that the main door alarm was not connected to the resident-staff communication and response system, nor 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. He indicated that he believed that the sound was heard everywhere on the main floor, as well as the second floor. The alarm was sounded once again, and the maintenance staff and Inspector left the main entrance area to go towards the nearest nurses' station located by the physiotherapy room, and near the Spence Unit, and barely heard the sound of the alarm. Inspector #592 who was on the second floor on Cartier did not hear the main door alarm.

The Administrator explained that the home had not considered the main door as a door leading to the outdoors, because it did not lead immediately and directly to the outdoors, due to the vestibule between the inner and outer doors. As a result, the main door's alarm had not been connected to the resident-staff communication and response system nor to an audio visual enunciator that was connected to the nurses' station nearest to the door with a manual reset switch at the door. She further indicated that she was not aware that the main door was not equipped with an alarm that allowed calls to be cancelled only at the point of activation, however was aware that the receptionist cancelled the alarm using a button at the receptionist desk.

The licensee has failed to ensure that all doors in the home, particularly the basement level doors leading to the outside of the home were kept closed and locked, equipped with a door access control system that was kept on at all times, and equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation and was connected to the resident-staff communication and system, or was connected to an audio visual enunciator that was connected to the nurses' station nearest to the door and had a manual reset switch at each door, as residents had access to this non-residential area of the home.

Inspector #545 was informed that the basement level was a non-residential area of the home, and could only be accessed via an access code entered on a keypad available in the elevator. The inspector was also informed that residents were not provided with the access code and/or a swipe key.

On April 20, 2016 Inspector #592 and #545 reviewed elevator #1: Inspector #592 was on the third floor and Inspector #545 was in the basement. Inspector #545 signaled elevator #1 from the basement by pressing the arrow pointing up button. Inspector #592 was waiting in elevator #1, on the third floor; resident #031 entered the elevator and pressed the first floor button. The elevator descended to the first floor, and the resident exited the elevator and a family member entered the elevator and indicated he/she was going to the third floor. After pressing the third floor button, the button was lit with a red light; the basement button was not lit to indicate it was on route to the basement. The elevator descended to the basement, a non-residential area of the home, and the doors opened. Inspector #545 observed this non-residential area of the home, and noted that there were four unlocked doors leading to the exterior, used by staff to enter and exit from the home.

Resident #036 indicated to Inspector #545 that he/she regularly used either elevator to go from the third to the first floor and on many occasions he/she ended up in the basement without having signaled it. He/she further indicated that once in the basement, the elevator door opened to the basement, and on occasion with no person outside the elevator, thus providing access to a restricted area.

Resident #042 indicated to Inspector #545 that he/she used either elevator to go from the third floor to the main floors for meals. The resident indicated that on many occasions, the elevators have descended to the basement without having signaled it, added that he/she was told by maintenance staff that anyone signaling the elevator from the basement was given priority. Resident #042 further indicated that on many occasions, upon elevator doors opening in the basement, no person was outside the elevator, thus providing access to a restricted area. He/she indicated to the inspector that he/she knew the access code of the elevator to the basement, added that even if it was not written, it was the same code as other exit doors in the home, where a sticky with the code was posted just below the keypad. The resident further indicated that he/she had been in the basement on his/her own, mainly to speak with the laundry staff re: issues with clothes.

In the basement level the following doors leading to the outside of the home were closed but were not locked, they were not equipped with a door access control system that was kept on at all times, and they were not equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation and connected to the resident-staff communication system, or was not connected to an audio visual enunciator that was connected to the nurses' station nearest to the door and had a manual reset switch at each door, as residents had access to this non-residential area of the home:

(a) Door leading to a stairwell which then led to a set of double exterior doors on the main floor. Note that a red sign indicating "this door is equipped with an alarm, use in case of emergency only" was posted on the double-doors, but when left opened by the Inspector on April 21, 2016 at 1547, no audible door alarm was activated. This exterior door led to the parking lot and Cartier Street, a busy street. Once outside, the inspector was unable to re-enter, unless using a swipe key.

(b) Door #051 was located off the main basement hallway and leading into the Maintenance Staff area, which then led to a stairwell and to an exterior door on the main floor. This exterior door led to the home's gazebo and a ravine, as well as the parking lot and Cartier Street, a busy street. Once outside the inspector was unable to re-enter via the same door as it was locked.

(c) Exit Door #14 was located by the staff room via an unlocked closed door. This exterior door led to a parking lot and Spence Street, a busy street. Once outside, the inspector was not able to re-enter as the door was locked, unless using a swipe key.

(d) Exit Double-doors #19 was located at the far end of the basement near the shipping and receiving dock. This exterior door led to a parking lot and Spence Street, a busy street. Once outside, the inspector was not able to re-enter as the door was locked, unless pressing a green button by the door alerting staff.

During an interview with Maintenance Staff #129, who was one of the most senior staff in the maintenance department, he indicated that all four doors identified above, particularly the basement level doors leading to the outside of the home were kept closed but not locked between the hours of 2000 and 0500. He further indicated that they were equipped with a door access control system, but that it was not kept on at all times; only between the hours of 2000 and 0500. Maintenance Staff #129 activated all door alarms, in presence of Administrator and Inspector by entering an access code in a console located at the nurse's/PSW station, an audible door alarm was heard. To cancel the alarm, the maintenance staff re-entered the same access code into the console at the nurse's/PSW station. He confirmed that those doors were connected to an audio visual enunciator that was connected to the nurses' station nearest to the door, but the doors were not equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation, nor were equipped with a manual reset switch at each door.

The lack of elevator security and access to unlocked and unalarmed doors presents a potential risk to residents of the home. These doors in the basement do lock from the outside, adding another level of risk as residents would have access to go out of these four doors however the resident would not be able to return back inside the home. (545)

2. The licensee failed to ensure that all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff.

On April 18, 2016 at 0939, during the initial tour, Inspector #545 observed the home's physiotherapy room (#1114) located on the main floor near the elevators and across from the cafeteria (large dining room) with the door opened and unlocked. There were no residents or staff in the room at the time of the observation. The inspector observed on a counter, a hydrocollator steam pack machine in use. The exterior of the machine was very hot to touch and the interior of the machine was filled with very hot water and two hot packs. Three exercise bicycles were observed as well as parallel bars.

During an interview with the Physiotherapy Assistant (PTA), he indicated that the door to the physiotherapy room should be closed and locked at all times when not in use due to potential risks of injury to residents, such as the hydrocollator steam pack machine which is always in use, with

temperature of water at 160 degree Fahrenheit (or 71 degree Celsius) when taken with the home's thermometer in presence of the inspector. The PTA further indicated that the equipment in the room were also potential risks of injury to residents, added that when not in use, the door was always closed and locked.

The FSS and Acting ESS on April 25, 2016 indicated that the physiotherapy room was equipped with a lock to restrict unsupervised access to this room by residents and should be closed and locked when not in use.

The Food Service Supervisor/Acting Environmental Services Supervisor (ESS) indicated that the basement was a non-residential area, and that doors leading to this area, were equipped with locks to restrict unsupervised access by residents.

Maintenance Staff #102 and #129 indicated that the basement was a non-residential area, accessed by staff with a code in the elevator and/or stairs. They indicated that residents did access the basement, mostly to go to the laundry room. They both indicated that the door to the shop was kept locked to prevent tools from disappearing, but also to restrict unsupervised access by residents when it was not being supervised by staff. Maintenance Staff #129 indicated that many electrical tools were easily accessible in the shop and could pose a risk of injury to residents.

On April 21, 2016 at 1419 Inspector #545 observed the basement Maintenance Shop door (#055) open and unlocked. There was no staff in the front part of the shop where electrical tools were easily accessible. There was no one in the office, in the back of the shop, therefore the door leading to non-residential area was not locked or supervised by staff.

The Administrator and Food Service Supervisor covering for the Acting ESS indicated to Inspector #545 that they were aware that the residents could inadvertently arrive in the basement, a non-residential area, without having entered the access code in the elevator, therefore any doors unlocked when not being supervised by staff, would not restrict unsupervised access by residents, such as the maintenance shop. (545)

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

Aug 31, 2016
Oct 28, 2016(A1)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l’inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 6 day of May 2016

Issued on this 10 day of August 2016 (A1)

Issued on this 18 day of August 2016 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

JOELLE TAILLEFER
ANGELE ALBERT-RITCHIE
JOANNE HENRIE
MELANIE SARRAZIN
ANGELE ALBERT-RITCHIE - ()
JOANNE HENRIE - ()
MELANIE SARRAZIN - ()
JOANNE HENRIE - (A1)

JOELLE TAILLEFER - (A2)

Service Area Office / Bureau régional de services : Ottawa