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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Ottawa Service Area Office
347 Preston St 4th Floor
OTTAWA ON L1K 0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston 4iém étage
OTTAWA ON L1K 0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Apr 08, 2015;	2015_285546_0006 (A1)	O-001645-15	Resident Quality Inspection

Licensee/Titulaire de permis

VILLA MARCONI LONG TERM CARE CENTER
1026 BASELINE ROAD OTTAWA ON K2C 0A6

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

VILLA MARCONI
1026 BASELINE ROAD OTTAWA ON K2C 0A6

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

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PAULA MACDONALD (138) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee has requested an extension to the compliance date for Compliance Order #002 issued as a result of the Resident Quality Inspection (O-001645-15), conducted Februay - March 2015.

The licensee has provided a summary of progress made to date and an explanation of the factors that are delaying their ability to achieve full compliance by the original compliance date of April 8, 2015. The licensee has also provided an explanation of how resident safety will be ensured until such time as compliance is achieved.

The compliance date has now been amended to reflect a new date of April 30, 2015. No other changes have been made to the Inspection Report or to the "Order(s) of the Inspector" document.

Issued on this 8 day of April 2015 (A1)

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

Original report signed by the inspector.

Ontario

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

PAULA MACDONALD (138) - (A1)

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): February 23-27, March 2 -5, 2015.

Inspection of the following logs: O-001632-15, O-001307-14, O-001300-14, O-001130-14, O-000991-14, O-000893-14 and O-000370-14, occurred during the RQI inspection period.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, the appointed assistant for the Residents' Council, the Chair of Family Council, the Administrator, the Director of Care (DOC), the assistant Director of Care (ADOC), the Resident Care Manager (RCM), the Restorative Care/BSO Lead, a restorative care aide, the RAI Coordinator, the Activity & Recreation Manager, several activity aides, the Environmental Lead, several Housekeeping aides, the Food Services Manager, several dietary aides, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), one Physiotherapist, one OT/PT Assistant.

In addition, the inspectors toured residential and non residential areas, observed resident care, observed meal and snack services, reviewed several of the home's policies and procedures, observed a medication pass including medication room, observed recreation activities, observed exercise therapy, reviewed minutes for Residents' Council and Family Council, reviewed the Satisfaction Survey document, reviewed Resident Health Care records, including plans of care, medication and treatment records and PSW Point of Care

documentation, reviewed the Recreation Calendars, reviewed staffing schedules, reviewed food service documentation, and reviewed maintenance schedules.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

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

8 WN(s)
3 VPC(s)
3 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 #7: 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 that the home's equipment was kept clean and sanitary, as per LTCHA, 2007, S.O. 2007, c.8, s. 15 (2) (a).

During this RQI Inspection, Inspector #549 observed on a specific day in February 2015 that Resident #030's wheelchair had dried debris on the seat cushion and dried liquid drip marks along the side of the seat cushion and down the side of arm rests and wheels. The same was observed on another day in February 2015 by Inspector #546. PSW S#102 wiped the seat cushion. When asked by Inspector #546 when was the last time Resident #030's wheelchair was cleaned, S#102 stated she did not know and replied it was night staff's duty and that it was not being done.

Inspector #546 asked the agency Charge RN S#112 where the wheelchair cleaning log was located; she replied to ask the regular staff. PSW S#105 indicated to inspector that the wheelchair cleaning log was located in the Nights' Check Binder. The inspector located the Nights' Check Binder at the nursing station's desk and in the binder, it was noted that there were several undated residents' lists and several unfilled forms of which served copies that were identified as Monthly Equipment Cleaning Tracking Form – all undated and not filled. On the white board of the documentation room (located at the back of the nursing station) was a sheet titled Night Shift, identified with the **clean wheelchairs** with 6 residents' names to be up.

When Inspector #546 showed the form and list to S#105, he stated it is not being done and that the best person to speak to about wheelchair cleaning was the Restorative Care/BSO person (S#111).

In an interview with the Restorative Care/BSO person (S#111), she indicated that she was responsible for organizing that all wheelchairs are cleaned twice a year (in May and October) through an external service provider. When asked if there was a process

for wheelchair cleaning outside of those 2 times in the year, S#111 confirmed that if a chair was soiled, it should be wiped immediately, otherwise it was the night staff's duty; she further added that it was not being done.

On a specific day in February 2015, during a discussion with Inspectors #546 and 549, when asked if there was a process or program for cleaning wheelchairs, other than twice a year by a service provider as indicated by S#111, the DOC acknowledged that there used to be a process for equipment cleaning but that it did not occur on nights as reported. When provided with the forms and lists found on the units, the DOC reported that the forms in the binder did not belong to the Home and that he was unaware of the titled Night Shift list's existence on the unit's white board. The DOC did indicate that it was the responsibility of the PSWs to wipe each piece of equipment's contact surface after every individual use and re-affirmed that it was the responsibility of night shift PSWs to clean and maintain wheelchairs, gerichairs, walkers and other equipment; he further added that if it was not documented, it was considered to be not done. [s. 15. (2) (a)]

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the abuse of a resident from another resident occurred, it was immediately reported to the Director.

On a specific day in October 2014 @ 17:27 there was an altercation between Resident #010 and Resident #009. The Critical Incident Report states that Resident #010 hit Resident #009 "hard" over the head with his/her hand.

The unit RPN documented on the Critical Incident Report that Resident #009 sustained a red bruise on his/her chin.

The Director of Care was notified of the abuse of Resident #009 by the unit RPN on that day in October 2014, immediately after the incident. At that time, the Director of Care requested that the unit RPN arrange for 1:1 staffing for Resident #010 immediately.

The Director was notified of the abuse on a different day in October 2014 using the Ministry of Health and Long Term Care Critical Incident Report.

During an interview with the Administrator on March 5, 2015 it was stated to Inspector #549 that the Director was not notified immediately of the abuse to Resident #010 which occurred in October 2014. [s. 24. (1)]

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home is a safe and secure environment for its residents as it relates to secure outside areas.

During the course of the inspection, it was observed that there were residents outside in the secure outside area in -20°C weather, primarily for the purpose of smoking in the designated area. Inspector #138 determined that residents could access this outside secure area through two points, the garden doors in the residential lobby of the LTC home and another point through the main lobby of the building (not considered to be a part of the LTC home). It was also noted by the inspector that the garden doors open automatically when the inspector stood in front of the doors and that once through these doors the second set of doors to the secure outside area also open automatically. It was noted by the inspector that there was a keypad located near the garden terrace doors but no code was required to access the doors and, instead, the doors opened automatically.

The inspector identified one of the residents seen accessing the secure outside area, and spoke with the RPN, Staff #113, who works on the resident's home area. The RPN stated to the inspector that the resident often leaves the home area to smoke outside and often does not return to the home area when finished smoking, electing to say on the ground floor in the common areas. The inspector inquired as to how the home monitors the resident and other residents in the secure outside area especially in extreme weather conditions such as temperatures below -20°C and the RPN stated that she was not be aware of the residents whereabouts but that management would monitor the residents.

The inspector spoke to the Administrator and the Director of Care about the monitoring of residents in the secure outside area especially in extreme weather conditions and both stated that the home areas are aware of all residents' whereabouts. The Administrator also demonstrated that the receptionist at the front desk of the building (not within the LTC home) has a security monitor for many areas around the building including the secure outside area. The inspector noted that the receptionist hours are 9:00am to 4:00pm. The Administrator stated that he has access to the security feed for the secure outside area but acknowledges that he does not monitor it on a routine basis. The Director of Care stated to the inspector that the garden terrace doors were unlocked at 5:30am until at 8:00pm to allow residents access to the designated smoking area. The inspector requested the home's policy required in accordance with section 9. (2) of the regulation that is to deal with doors leading to outside secure areas. The home was not able to produce a policy specific to these doors. [s. 5.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 10. Elevators
Specifically failed to comply with the following:

s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Findings/Faits saillants :

1. The licensee failed to comply with section 10.(1) of the regulation in that the licensee failed to ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents.

Inside the doors of the designated LTC home portion of the building is a residential lobby with a bank of two elevators that services the area of the LTC home known as Phase 1. Within the bank of elevators is Elevator #1 that services the basement, ground, and the second and third floors containing resident home areas. Elevator #2 also services the basement, ground, and both second and third floors but also has a rear door that accesses the serveries on second and third floors, the service corridor on the ground floor, and a small room on the basement floor that contains an exit door. It was noted by Inspector #138 that a person can enter Elevator #1 and Elevator #2 on floors two and three, where the resident home areas are contained, by punching in a code to a key pad located external to the elevator and then calling the elevator by pushing the appropriate up or down button. The code on the key pad is known by many residents and, according to the Administrator and the Director of Care, the coded key pad is not intended to restrict residents from using the elevator as there is a secure unit in the home that is designed to limit resident movement. Elevator #1 and Elevator #2 on the ground floor in the residential lobby do not have a

key pad and do not require a code to access the elevator. Any person, once inside either of these two elevators from any floor, has full access to all floors.

For Elevator #1, full access meant that a person can access the basement by selecting the door to the basement from within the elevator. Once in the basement from the elevator the inspector noted that there was a laundry room, a chemical labeled as corrosive titled Emeral Multi Surface Cream on a shelf, and a corridor with storage of equipment. The inspector followed the corridor and noted that it led to Elevator #3 which, when on the elevator, allowed full accessibility to the serveries on Gentle Care and Complex Care. The corridor in the basement also led to an unlocked and unalarmed door to stairwell H. Once inside stairwell H, the inspector was able to proceed up a flight of steps to the ground floor and exit through an unlocked and unalarmed door into a hallway of the building not designated as the LTC home. This hallway, in turn, led to the main entrance of the building which was noted by inspectors on several occasions during the course of the inspection to unsecured.

For Elevator #2, full access meant that a person can access the basement the same as with Elevator #1 or can alternately select the rear door of the elevator to the basement. It was noted by the inspector that when the rear door of the elevator to the basement was selected from any floor that the elevator went to the basement and the rear door opened to a small room containing a battery charger, an opened door to the laundry room and from there complete access to the basement including stairwell H, and an unlocked exit door that was opened by the inspector and found to lead to an outside stairwell that further led to the parking lot. There was a sign on this exit door that indicated that the door was to be locked at 4pm each day.

Additionally, with Elevator #2, once inside the elevator at any floor a person can select the ground rear door and access the service corridor on the ground floor. Located in the service corridor is the main kitchen, a staff room, an unlocked storage closet, and an unlocked and unalarmed exit to the outside within stairwell C. Also contained in the service corridor were two rooms, one labeled as the garbage room and the other labelled as receiving. The doors to both these rooms were noted to be unlocked and both rooms were noted to have an exit door that was observed to be unlocked and unalarmed, leading to the front parking lot.

Finally, with Elevator #2, once inside the elevator a person can select the rear door on second and third floors and access the serveries on these floors.

Over in the section of the building known as Phase two, there is Elevator #3 which

services the basement, ground, and second floor. Elevator #3 has a key pad that requires a code for entry however it is the same code used with Elevator #1 and Elevator #2 and is known and used by residents. Residents were observed inside Elevator #3 over the course of the inspection. Once inside Elevator #3, any person has full access to the basement and the rear doors that open to the serveries on Gentle Care and Complex Care.

Multiple discussions were held with the Administrator and the Director of Care over the course of the inspection and both stated that the basement and the service corridor the ground floor were not to be accessed by residents and further stated that the doors leading to exits in these areas are not always kept locked as they are not meant to be accessible to residents. The Administrator and Director of Care also acknowledged that the serveries on the second and third floor of Phase 1 as well as the serveries on Complex Care and Gentle Care on Phase 2 are not to be resident accessible areas. Both stated that all these areas are accessible to residents related to the current inability inside the three elevators to restrict resident access to these areas. [s. 10. (1)]

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 #6: 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 failed to ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

Inspector #138 observed on a specific day in February 2015, that the privacy curtains in some shared rooms were not long enough to fully extend in the ceiling track leaving an approximate five feet opening at the entrance to the room. Further, it was noted in another shared room that the privacy curtain was not attached to many of the hooks in the ceiling track causing several hooks to become stuck in the track which then prevented the privacy curtain from being moved where needed to ensure privacy. It was further noted on a different day in February 2015, that the privacy curtain in another shared room was also not attached to many of the hooks in the ceiling track causing several hooks to become stuck in the track which prevented the privacy curtain from being moved where needed to ensure privacy. [s. 13.]

WN #3: 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).

Findings/Faits saillants :

1. The licensee failed to comply with section 9.(1)1.i. of the regulation in that the licensee failed to ensure that the all doors leading to stairwells and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident or doors that residents do not have access to must be kept closed and locked.

Inspector #138 toured the home on February 23, 2015 and noted that the interior garden doors located in the lobby on the ground floor of the LTC home that led to the designated secure outside area opened automatically when the inspector stood in front of them. Once the interior doors opened, the inspector was able to enter into a vestibule that also had a single door off to the side. There was a key pad beside this single door however the door was opened by the inspector without entering a code into the key pad. Once through the door the inspector was in stairwell H and was able to exit through an unlocked door into a hallway of the building that is not designated as part of the LTC home. This hallway, in turn, led to the main entrance of the building which was noted by inspectors on several occasions during the course of the inspection to be unsecured. In addition, when in stairwell H, the inspector had full access to the basement which, according to the Administrator and the Director of Care, is a non-residential area. Within the basement the inspector found the laundry room, a chemical labeled as corrosive titled Emeral Multi Surface Cream on a shelf in the corridor, and a corridor with the storage of various equipment. Within this corridor

there was also access to three elevators. Once on these elevators, the inspector was able to access the service corridor on ground floor with unlocked exits to the outside as well as access to the serveries located throughout the home. Again, the Administrator and Director of Care stated that the service corridor on ground floor and the serveries were non-residential areas.

By the end of the inspection, the home was able to secure the side door located in the vestibule of the garden terrace doors and prevent access to stairwell H. [s. 9. (1) 1. i.]

2. The licensee failed to comply with section 9.(1)1.iii of the regulation in that the licensee failed to ensure that the all doors leading to stairwells and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident or doors that residents do not have access to must be equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and is connected to the resident-staff communication and response system or is connected to an audiovisual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at the door.

It was noted during the course of the inspection that the double doors on the ground floor outside stairwell H, considered by the home to be the front doors to the LTC home portion of the building, were locked but not alarmed. On March 2, 2015, Inspector #138 held these double doors open for several minutes and noted the absence of an alarm required to be cancelled at the point of activation. The inspector immediately spoke with the Director of Care and the Resident Care Manager regarding these doors and both stated that the double doors were considered to be the front doors to the LTC home and that these doors are locked but also alarmed for specific residents through the Wanderguard System. Both further explained that these doors are not alarmed otherwise nor are they connected to the pagers (resident-staff communication and response system) with the exception of specific residents through the Wanderguard System.

On March 3, 2015, Inspector #138 spoke with the Environmental Lead, Staff #109, regarding door alarms, specifically doors exits and doors to stairwells. The Environmental Lead stated that the only alarm on these doors is an alarm that sounds if the push bar is depressed for several seconds but that no door will alarm if the door is opened. The inspector then proceeded with the Director of Care to the ground floor stairwell H door which was unlocked by entering a code into the keypad and then held open several minutes. No alarm was sounded. Further, the Director Care stated that no door in the home is alarmed or connected to the pagers. On March 4, 2015, the

Administrator and the Director of Care further stated that no door in the home was connected to audiovisual enunciator at the nursing stations.

On March 3, 2015, after discussing the door to stairwell H with the Director of Care, the inspector then proceed with the Director of Care and the Administrator to the second floor Phase 1 and unlocked and held open the door to stairwell B located across from the resident dining room. The door was held open for several minutes and no alarm sounded.

The inspector spoke with RPNs on two different units regarding doors to exits and stairwells. The RPN on Complex Care, Staff #107, stated that doors to exits and stairwells show up on the pagers only for those specific residents with the Wanderguard System. Staff #107 further stated that these doors are not connected to the pagers otherwise. The inspector also spoke with the RPN on third floor, Staff #113, who also stated that doors to exits and stairwells only alarm and show up on the pagers for those specific residents with the Wanderguard System. Staff #113 further stated that these doors to exits or stairwells are not connected to the enunciator. [s. 9. (1) 1. iii.]

Additional Required Actions:

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

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 exit doors are kept locked, to be implemented voluntarily.

WN #4: 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. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

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:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

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:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is released from the physical device and repositioned at least every two hours.

Resident #018 was observed over two days in February 2015, sitting in a wheelchair with a front closure lap belt applied. The physician's order for the lap belt states it is to be applied at all times when Resident #018 is in the wheelchair to prevent falling.

On a specific day in February 2015, Inspector #549 found that Resident #018 was not physically or cognitively able to undo the lap belt.

PSW S#106 indicated to Inspector #549 that Resident #018 is not responsive when asked to follow directions, but will follow with his/her eyes and may turn his/her head when spoken to. PSW S#106 also stated that Resident #018 would most likely fall out of the wheelchair if the lap belt was not applied.

RPN S#107 confirmed the front closing lap belt for Resident #018 is considered a physical restraint.

PSW S#106 was assigned to provide care to Resident #018 on a specific day in February 2015. During an interview on the same day, PSW S#106 indicated to Inspector #549 that Resident #018 did not have his/her lap belt released nor was the resident repositioned every two hours.

During an interview on a specific day in February 2015, PSW S#108 who was assisting with the care of Resident #018 stated the resident's lap belt is not released and the resident is not repositioned every two hours.

During an interview on a specific day in February 2015, RPN S#107 indicated to Inspector #549 that the staff do not reposition Resident #018 every two hours. RPN S#107 indicated that staff is aware they are required to release the restraint and reposition Resident #018 every two hours but it is not being done.

On another day in February 2015, Inspector #549 found Resident #030 was not physically or cognitively able to undo the front closing lap belt. PSW S#102 indicated to Inspector #549 that Resident #030 has undone his/her lap belt in the recent past. RPN S#101 confirmed the lap belt for Resident #030 is considered a physical restraint.

Resident #030 was observed sitting in a wheelchair on several days in February 2015, with a front closure lap belt applied. The physician's order for the lap belt indicates "apply lap belt on wheelchair for safety".

On a specific day in February 2015, during an interview with PSW S#110, it was indicated to Inspector #549 that Resident #030 is not released from the restraint and repositioned every two hours.

On two separate days in February 2015 during an interview, PSW S#102 indicated to Inspector #549 that the residents with restraints are not being released and repositioned every two hours due to workload issues. PSW S#102 indicated to Inspector #549 that when residents are toileted in the morning, the restraint is released and then most of residents go back to bed at 1:00pm.

On a specific day in February 2015, during an interview PSW S#105 indicated to Inspector #549 that the residents are released from the restraint during toileting time

and if they attend physiotherapy.

Resident #038 was observed by Inspector #549 on three different days in February 2015, sitting in a tilt chair with a lap belt and table top applied. Inspector #549 found that Resident #038 was not able to remove the lap belt but was able of remove the table top. RPN S#101 confirmed that the lap belt is considered a physical restraint.

PSW S#110 indicated to Inspector #549 that Resident #038 is in a tilt chair and it is tilted at different angles several times a day. Inspector #549 inquired if the restraint is released every two hours, PSW S#110 indicated not always.

PSW S#110 also indicated to Inspector #549 that those residents who are in a tilt chair are tilted during the day, but the restraint is not released and the resident is not repositioned.

PSW S#102 indicated to Inspector #549 that Resident #038 is not being repositioned every two hours and the restraint is not being released.

PSW S#102 also indicated to Inspector #549 that there is a workload issue on the unit and there is not always time available to release and reposition residents with restraints every two hours.

On a specific day in February 2015, PSW S#105 indicated to Inspector #549 that the residents with restraints are being repositioned and the restraint is being released when the resident is toileted.

RPN S#101 indicated to Inspector #549 that the residents are toileted and are released and repositioned during the toileting time, but was not able to confirm this occurs every two hours. [s. 110. (2) 4.]

2. The licensee failed to ensure all assessment, reassessment and monitoring, including the resident's response is documented.

The home policy dated February 2012, titled Restraint: Physical, Chemical and Environmental Policy #NM-II-R008 page 4 Section C states the following: The use of a physical restraint must be documented and include the following: all assessment, reassessment and monitoring. Reassessments are at a minimum to be done q8hr by physician, RN (EC), or RN/RPN.

During an interview with Inspector #549 on a specific day in February 2015, RPN S#101 indicated that the registered staff are responsible for documenting on the "Restraint and Personal Safety Device Monitoring Record" form once a shift indicating that the resident's condition was reassessed and the effectiveness of the restraint was reassessed.

On a specific day in February 2015, during an interview, RPN S#101 indicated to Inspector #549 that she completes a reassessment of the residents with a restraint once per shift but does not always sign on the Restraints and Personal Device Monitoring Record sheet.

During an interview on a different day in February 2015 with Inspector #549, RPN S#101 indicated that the "Restraint and Personal Safety Device Monitoring Record" was not consistently signed by a member of the registered staff once a shift.

Resident #018's Restraint and Personal Safety Device Monitoring Record was reviewed by Inspector #549 for a period in February 2015. There are seventy-six registered staff shifts (days, evenings and nights) for this time period. Thirty of the seventy-six shifts for this time period do not have a registered staff's signature indicating that the resident's condition was reassessed and the effectiveness of the restraint was reassessed.

Resident #030's Restraint and Personal Safety Device Monitoring Record was reviewed by Inspector #549 for a period in February 2015. There are seventy-six registered staff shifts (days, evenings and nights) for this time period. Fifty of the seventy-six shifts for this time period do not have a registered staff's signature indicating that the resident's condition was reassessed and the effectiveness of the restraint was reassessed.

Resident #038's Restraint and Personal Safety Device Monitoring Record was reviewed by Inspector #549 for a period in February 2015. There are seventy-six registered staff shifts (days, evenings and nights) for this time period. Forty-eight of the seventy-six shifts for this time period do not have a registered staff's signature indicating that the resident's condition was reassessed and the effectiveness of the restraint was reassessed.

During an interview on a specific day in February 2015, the Director of Care indicated that the expectation is that the registered staff document that the resident's condition was reassessed and that the effectiveness of the restraint was reassessed once a

shift. The Director of Care also indicated during the interview to Inspector #549 that the lack of documentation indicates the resident's condition and reassessment of the effectiveness of the restraint was not done. [s. 110. (7) 6.]

3. The licensee failed to ensure that every release of the device and all repositioning are documented.

The home's restraint policy dated February 2012, titled Restraint: Physical, Chemical and Environmental Policy #NM-II-R008 on page three, bullet eight states: The resident is released from the device and repositioned at least every two hours and more frequently if required due to resident condition or circumstances.

The Restraint: Physical, Chemical and Environmental Policy #NM-II-R008 page four Section C states the following: The use of a physical restraint must be documented and include the following: every release of the device, all repositioning the removal or discontinuance of the device, including time of removal or discontinuance.

RPN #S101 confirmed with Inspector #549 on a specific day in February 2015, that the home uses the Restraint and Personal Safety Device Monitoring Record (form 003) to document the release of the restraint and all repositioning of the resident.

The legend for the Restraint and Personal Safety Device Monitoring Record indicates an A for the Application of the restraint, an R for the restraint release and reposition and an O for the restraint removed/off.

During an interview with Inspector #549 on the same day in February 2015, RPN S#101 indicated that the PSWs are responsible for documenting on the "Restraint and Personal Safety Device Monitoring Record" form when the restraint is released and the resident is repositioned.

The Restraint and Personal Device Monitoring Record form for Resident #018 was reviewed by Inspector #549 for a period in February 2015. There is no documentation during a period in February 2015, indicating that Resident #018 has the lap belt released and was repositioned at least every two hours. The restraint documentation for a time period in February 2015, indicates that Resident #018 had the restraint applied regularly for a period of four to six hours at a time without the restraint being released or the resident being repositioned.

Inspector #549 reviewed the Restraint and Personal Safety Device Monitoring Record

for Resident #030 for a period in February 2015. The Restraint and Personal Safety Device Monitoring Record indicated that the restraint was released and the resident was repositioned twice in that period in February 2015. The restraint documentation for that time period in February 2015 indicates that Resident #030 had the restraint applied regularly for a period of four to seven hours at a time without the restraint being released or the resident being repositioned.

Inspector #549 reviewed the Restraint and Personal Safety Device Monitoring Record for Resident #038 for a period in February 2015. The Restraint and Personal Safety Device Monitoring Record indicated that the restraint for Resident #038 was released and the resident was repositioned three times in that period in February 2015. The Restraint and Personal Safety Device Monitoring Record for Resident #038 in tat period of time in February 2015 indicates that Resident #038 had the restraint applied regularly for a period of four to six hours at a time without the restraint being released or the resident being repositioned.

During an interview on a specific day in February 2015, the Director of Care stated to Inspector #549 that the expectation of the home is that the PSWs document on the Restraint and Personal Safety Device Monitoring Record hourly, that the resident with a physical restraint is checked and every two hours that the resident had the restraint released and the resident was repositioned. [s. 110. (7) 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 in that when using restraints, a resident shall be released from the physical device and repositioned at least every two hours and that all assessment, reassessment and monitoring, including a resident's response, be documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that it complied with its policy to promote zero tolerance as per the LTCHA, 2007, S.O. 2007, c. 8, s. 20(1), when the abuse of a resident was not immediately reported to the Director, as indicated under the LTCHA, 2007, S.O. 2007, c. 8, s. 20 (2) (d).

On a specific evening in April 2014, a registered staff was called to the Gentle Care Unit's TV room by a resident. The registered staff found Resident #011 lying on the floor bleeding from the head, wheelchair at the resident's side and another resident was nearby. When the registered staff asked resident #011 what happened, the resident replied that a resident had pushed him and pointed at resident #012.

Resident #011 was transferred to ER for a laceration and minor head trauma. At the time of the incident, the registered staff in charge of the unit was an agency RPN, as confirmed by the Director of Care.

The Director was notified, through the CIR system, of the abuse on April 25, 2014 at 11:11am.

On March 5, 2015, in a discussion with Inspector #546, the Director of Care confirmed that the Charge Nurse would not have known to report this and therefore, the Resident Care Manager (RCM) would have been informed the following day at the morning report meeting; the RCM would have submitted the report later on that morning.

Thus, the home's policy on Zero Tolerance for Resident Abuse and Neglect Policy Number ADM-VIII-005 (dated April 2013), Reporting Resident Abuse and Neglect - Section A Mandatory Reports and Reporting Procedures, was not complied with. [s. 20. (1)]

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 in that the home must immediately notify the Director of any suspected, witnessed or alleged incidence of abuse, to be implemented voluntarily.

Issued on this 8 day of April 2015 (A1)

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, L1K-0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, L1K-0E1
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) : PAULA MACDONALD (138) - (A1)

Inspection No. / No de l'inspection : 2015_285546_0006 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : O-001645-15 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Apr 08, 2015;(A1)

Licensee / Titulaire de permis : VILLA MARCONI LONG TERM CARE CENTER
1026 BASELINE ROAD, OTTAWA, ON, K2C-0A6

LTC Home / Foyer de SLD : VILLA MARCONI
1026 BASELINE ROAD, OTTAWA, ON, K2C-0A6

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

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

To VILLA MARCONI LONG TERM CARE CENTER, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee is required to ensure the safety of all residents accessing secure outside areas by developing and implementing a policy that considers, at a minimum, monitoring of residents, maintenance of these areas, and weather dependent considerations. This policy shall also include the requirement outlined in section 9.(2) of the regulation which states that the licensee must ensure a written policy dealing with when doors leading to outside secure areas must be locked or unlocked to permit or restrict unsupervised access to those areas by residents.

Grounds / Motifs :

1. The licensee failed to ensure that the home is a safe and secure environment for its residents as it relates to secure outside areas.
During the course of the inspection, it was observed that there were residents outside in the secure outside area in -20°C weather, primarily for the purpose of smoking in the designated area. Inspector #138 determined that residents could access this outside secure area through two points, the garden doors in the residential lobby of the LTC home and another point through the main lobby of the building (not considered to be a part of the LTC home). It was also noted by the inspector that the garden doors open automatically when the inspector stood in front of the doors and that once through these doors the second set of doors to the secure outside area also open automatically. It was noted by the inspector that there was a keypad located near the garden terrace doors but no code was required to access

the doors and, instead, the doors opened automatically.

The inspector identified one of the residents seen accessing the secure outside area, Resident #006, and spoke with the RPN, Staff #113, who works on the resident's home area. The RPN stated to the inspector that Resident #006 often leaves the home area to smoke outside and often does not return to the home area when finished smoking, electing to say on the ground floor in the common areas. The inspector inquired as to how the home monitors Resident #006 and other residents in the secure outside area especially in extreme weather conditions such as temperatures below -20°C and the RPN stated that she was not be aware of the residents whereabouts but that management would monitor the residents.

The inspector spoke to the Administrator and the Director of Care about the monitoring of residents in the secure outside area especially in extreme weather conditions and both stated that the home areas are aware of all residents' whereabouts. The Administrator also demonstrated that the receptionist at the front desk of the building (not within the LTC home) has a security monitor for many areas around the building including the secure outside area. The inspector noted that the receptionist hours are 9:00am to 4:00pm. The Administrator stated that he has access to the security feed for the secure outside area but acknowledges that he does not monitor it on a routine basis. The Director of Care stated to the inspector that the garden terrace doors were unlocked at 5:30am until at 8:00pm to allow residents access to the designated smoking area. The inspector requested the home's policy required in accordance with section 9. (2) of the regulation that is to deal with doors leading to outside secure areas. The home was not able to produce a policy specific to these doors. (138)

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

Apr 08, 2015

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. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Order / Ordre :

The licensee is required to ensure that Elevator #1, Elevator #2, and Elevator #3, if used to transport residents, is equipped to restrict resident access to the service corridor on the ground floor, any area in the basement, the serveries on second and third floor of Phase 1, and the serveries on Complex Care and Gentle Care in Phase 2. While the licensee is addressing the elevators, the licensee must immediately mitigate any risks relating to the accessibility of any exits to the outside made available through the basement, service corridor on the ground floor, and any of the serveries.

Grounds / Motifs :

1. The licensee failed to comply with section 10.(1) of the regulation in that the licensee failed to ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents.
Inside the doors of the designated LTC home portion of the building is a residential lobby with a bank of two elevators that services the area of the LTC home known as Phase 1. Within the bank of elevators is Elevator #1 that services the basement, ground, and the second and third floors containing resident home areas. Elevator #2 also services the basement, ground, and both second and third floors but also has a rear door that accesses the serveries on second and third floors, the service corridor on the ground floor, and a small room on the basement floor that contains an exit door. It was noted by Inspector #138 that a person can enter Elevator #1 and Elevator #2 on floors two and three, where the resident home areas are contained, by punching in a code to a key pad located external to the elevator and then calling the elevator by pushing the appropriate up or down button. The code on the key

pad is known by many residents and, according to the Administrator and the Director of Care, the coded key pad is not intended to restrict residents from using the elevator as there is a secure unit in the home that is designed to limit resident movement. Elevator #1 and Elevator #2 on the ground floor in the residential lobby do not have a key pad and do not require a code to access the elevator. Any person, once inside either of these two elevators from any floor, has full access to all floors.
For Elevator #1, full access meant that a person can access the basement by selecting the door to the basement from within the elevator. Once in the basement from the elevator the inspector noted that there was a laundry room, a chemical labeled as corrosive titled Emeral Multi Surface Cream on a shelf, and a corridor with storage of equipment. The inspector followed the corridor and noted that it led to Elevator #3 which, when on the elevator, allowed full accessibility to the serveries on Gentle Care and Complex Care. The corridor in the basement also led to an unlocked and unalarmed door to stairwell H. Once inside stairwell H, the inspector was able to proceed up a flight of steps to the ground floor and exit through an unlocked and unalarmed door into a hallway of the building not designated as the LTC home. This hallway, in turn, led to the main entrance of the building which was noted by inspectors on several occasions during the course of the inspection to unsecured.
For Elevator #2, full access meant that a person can access the basement the same as with Elevator #1 or can alternately select the rear door of the elevator to the basement. It was noted by the inspector that when the rear door of the elevator to the basement was selected from any floor that the elevator went to the basement and the rear door opened to a small room containing a battery charger, an opened door to the laundry room and from there complete access to the basement including stairwell H, and an unlocked exit door that was opened by the inspector and found to lead to an outside stairwell that further led to the parking lot. There was a sign on this exit door that indicated that the door was to be locked at 4pm each day.
Additionally, with Elevator #2, once inside the elevator at any floor a person can select the ground rear door and access the service corridor on the ground floor. Located in the service corridor is the main kitchen, a staff room, an unlocked storage closet, and an unlocked and unalarmed exit to the outside within stairwell C. Also contained in the service corridor were two rooms, one labeled as the garbage room and the other labelled as receiving. The doors to both these rooms were noted to be unlocked and both rooms were noted to have an exit door that was observed to be unlocked and unalarmed, leading to the front parking lot.
Finally, with Elevator #2, once inside the elevator a person can select the rear door on second and third floors and access the serveries on these floors.

Over in the section of the building known as Phase two, there is Elevator #3 which services the basement, ground, and second floor. Elevator #3 has a key pad that requires a code for entry however it is the same code used with Elevator #1 and Elevator #2 and is known and used by residents. Residents were observed inside Elevator #3 over the course of the inspection. Once inside Elevator #3, any person has full access to the basement and the rear doors that open to the serveries on Gentle Care and Complex Care.
Multiple discussions were held with the Administrator and the Director of Care over the course of the inspection and both stated that the basement and the service corridor the ground floor were not to be accessed by residents and further stated that the doors leading to exits in these areas are not always kept locked as they are not meant to be accessible to residents. The Administrator and Director of Care also acknowledged that the serveries on the second and third floor of Phase 1 as well as the serveries on Complex Care and Gentle Care on Phase 2 are not to be resident accessible areas. Both stated that all these areas are accessible to residents related to the current inability inside the three elevators to restrict resident access to these areas.
(138)

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

Apr 30, 2015(A1)

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

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

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

i. kept closed and locked,

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

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

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

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

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

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, 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 :

The licensee shall ensure that the all doors leading to stairwells and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident or doors that residents do not have access to must be equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and is connected to the resident-staff communication and response system or is connected to an audiovisual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at the door.

Grounds / Motifs :

1. The licensee failed to comply with section 9.(1)1.iii of the regulation in that the licensee failed to ensure that the all doors leading to stairwells and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident or doors that residents do not have access to must be equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and is connected to the resident-staff communication and response system or is connected to an audiovisual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at the door.
It was noted during the course of the inspection that the double doors on the ground floor outside stairwell H, considered by the home to be the front doors to the LTC home portion of the building, were locked but not alarmed. On March 2, 2015, Inspector #138 held these double doors open for several minutes and noted the absence of an alarm required to be cancelled at the point of activation. The inspector immediately spoke with the Director of Care and the Resident Care Manager regarding these doors and both stated that the double doors were considered to be the front doors to the LTC home and that these doors are locked but also alarmed for specific residents through the Wanderguard System. Both further explained that these doors are not alarmed otherwise nor are they connected to the pagers (resident-staff communication and response system) with the exception of specific residents through the Wanderguard System.
On March 3, 2015, Inspector #138 spoke with the Environmental Lead, Staff #109, regarding door alarms, specifically doors exits and doors to stairwells. The Environmental Lead stated that the only alarm on these doors is an alarm that sounds if the push bar is depressed for several seconds but that no door will alarm if the door is opened. The inspector then proceeded with the Director of Care to the ground floor stairwell H door which was unlocked by entering a code into the keypad and then held open several minutes. No alarm was sounded. Further, the Director

Care stated that no door in the home is alarmed or connected to the pagers. On March 4, 2015, the Administrator and the Director of Care further stated that no door in the home was connected to audiovisual enunciator at the nursing stations.
On March 3, 2015, after discussing the door to stairwell H with the Director of Care, the inspector then proceed with the Director of Care and the Administrator to the second floor Phase 1 and unlocked and held open the door to stairwell B located across from the resident dining room. The door was held open for several minutes and no alarm sounded.
The inspector spoke with RPNs on two different units regarding doors to exits and stairwells. The RPN on Complex Care, Staff #107, stated that doors to exits and stairwells show up on the pagers only for those specific residents with the Wanderguard System. Staff #107 further stated that these doors are not connected to the pagers otherwise. The inspector also spoke with the RPN on third floor, Staff #113, who also stated that doors to exits and stairwells only alarm and show up on the pagers for those specific residents with the Wanderguard System. Staff #113 further stated that these doors to exits or stairwells are not connected to the enunciator.
(138)

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

Sep 11, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
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 8 day of April 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PAULA MACDONALD - (A1)

Service Area Office /
Bureau régional de services : Ottawa