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 sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 10, 2019	2019_674610_0007	002109-19	Critical Incident System

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

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

Caressant Care on Bonnie Place
15 Bonnie Place St Thomas ON N5R 5T8

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

NATALIE MORONEY (610), KARIN MUSSART (145), RHONDA KUKOLY (213)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 28, 29, 30, 31, May 15,16,17, 21, 22, 2019

This Critical Incident (CI) report #2730-000003-19, Log #: 002109-19/IL was completed related to a fire that required evacuation.

During the course of the inspection, the inspector(s) spoke with the Administrator, two Director of Care's, Care Coordinator, Maintenance Manager, Ward Clerk, Fire Investigator, Police Detective, Registered Nurse(s), Registered Practical Nurses, Personal Support Worker(s), Housekeeper, Clinical Corporate Manager, Fire Marshal, Continuous Quality Improvement Manager, Resident Assessment Instrument Nurse, Winmar Restoration, Security Agency Staff, and resident's.

Inspectors also observed resident care areas, resident care, exit doors, smoking area, call systems, and toured the homes areas. Inspectors also reviewed health care records, policies and other relevant documents and conducted interviews.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Hospitalization and Change in Condition
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **1 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	Légende 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.O. 2007, c.8, 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. LTCHA, 2007 S.O. 2007, c.8, s.5 . Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The home called the Ministry of Health and Long-Term Care's (MOHLTC) after-hours call

line Critical Incident related to an emergency evacuation related to a fire that occurred at the home.

The Critical Incident (CI) report showed that the fire caused smoke to envelope in one wing of the home. Identified residents had been transferred to the hospital.

Review of medical record documentation from the hospital showed that one identified resident had deceased while at hospital.

During an interview with the Administrator said that the Fire marshal was investigating the cause of the fire and that it was undetermined at the time of the inspection as to the cause of the fire.

The DOC said that they are aware where the fire started.

The home's policy “Smoking for Residents and Staff” stated in part that matches, lighter and cigarettes are dispersed by the charge nurse and residents may not carry lighters or matches on their person or keep same in their room.

Documented evidence showed that an identified resident had chosen to continue smoking. The goal for smoking was that the cigarettes and lighter would be stored with the nursing staff nightly and the intervention were the same.

There was no documented evidence that at the time of the fire that staff had been retrieving the resident lighter or was being provided cigarettes by the staff.

Record documentation showed that the RPN administered medication to the resident, but there was no documented evidence that the lighter and cigarettes were provided to the RPN by the resident at that time.

The DOC had completed an assessment for the resident that showed the resident had cognitive loss and was not safely disposing cigarettes. Documentation also showed that the resident had lost their smoking privileges.

The inspector had completed interviews with specific resident of the home that showed that they did not always return their lighters and never returned their cigarettes,

The identified resident told the inspector that they recalled the fire and smoke and what

occurred prior to the fire.

The Administrator told inspectors that the resident was monitored to decrease any further safety risks.

During interviews the Fire Marshal and the Police Detective both concluded that the investigation into the fire was ongoing and the origin of the fire was unknown at the time of this inspection as fire testing would still need to be completed in June 2019.

The licensee failed to ensure that the home was a safe place for residents being free from harm or risk of harm, and free from danger. [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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

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

The inspector was observing the an area in the home and found the exit door at the end of the wing unlocked, not alarmed and unattended.

The home's policy for "Call Bell and Door Alarm" stated in part that "the administrator will delegate who will have access to the bypass keys and the ESM will distribute them and provide education on hire on how to perform a bypass. Authorized employees who bypass a door are not allowed to leave the immediate area of the door as long as the door is on bypass in any resident areas".

During an interview with the PSW they told the inspector that staff are to ensure the door was locked. The PSW also said that staff unlocked the door and the door was put on bi-pass.

The Administrator and the DOC both said that staff are not to use that door for breaks and that if the door was left unattended by staff it would be locked and alarmed. [s. 9. (1)]

Issued on this 10th day of June, 2019

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

Original report signed by the inspector.

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NATALIE MORONEY (610), KARIN MUSSART (145), RHONDA KUKOLY (213)
Inspection No. / No de l'inspection :	2019_674610_0007
Log No. / No de registre :	002109-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 10, 2019
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	Caressant Care on Bonnie Place 15 Bonnie Place, St Thomas, ON, N5R-5T8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Suzanne Mezenberg

To Caressant-Care Nursing and Retirement Homes Limited, 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.O. 2007, c.8, 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 must be compliant with LTCH Act, 2007, s.5.

Specifically, the license must ensure:

a) The Identified residents and all others residents failing the home's smoking assessment and deemed unsafe to smoke must be closely monitored by staff.
b) All staff are to follow interventions put in place in the plan of care for identified residents and all other residents that smoke in the home.
c) The charge nurse will disperse matches, lighter and cigarettes to the residents as per the home's policy and will ensure that identified residents and all other residents will surrender these items upon return in the home.
d) The charge nurse will store and secure matches, lighter and cigarettes safely and will document the storage of these items as per policy.
e) The Administrator, Director of Care, and all staff will ensure that identified residents
and all other residents who do smoke are safe, independent smokers, and will not share cigarettes with other residents in the home.
f) The Administrator, and the Director of Care will develop and complete audits for resident identified that smoke to ensure that the homes policy, intervention and safety and security of all residents in the home has been implemented.

Grounds / Motifs :

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

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fire that occurred at the home.

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Documented evidence showed that an identified resident had chosen to continue smoking. The goal for smoking was that the cigarettes and lighter would be stored with the nursing staff nightly and the intervention were the same.

There was no documented evidence that at the time of the fire that staff had been retrieving the resident lighter or was being provided cigarettes by the staff.

Record documentation showed that the RPN administered medication to the resident, but there was no documented evidence that the lighter and cigarettes were provided to the RPN by the resident at that time.

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The licensee failed to ensure that the home was a safe place for residents being free from harm or risk of harm, and free from danger

The severity of this issue was determined to be a level 3 as there was actual harm. The scope of the issue was a level 3 as all residents in the B wing had to be evacuated. Compliance History was a level 2 as there was no current noncompliance issued in previous inspections. (610)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 02, 2019

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 10th day of June, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Natalie Moroney

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