Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 22, 2015	2015_346133_0039	O-001661-15	Follow up

Licensee/Titulaire de permis

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

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

CARLETON LODGE
55 LODGE ROAD R. R. #2 NEPEAN ON K2C 3H1

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): September 15, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, the Program Manager of Resident Care, and the Facility Supervisor. The inspector also communicated via email with a Security Adviser with the City of Ottawa and with the Program Manager for Corporate Security with the City of Ottawa.

During the course of the inspection, the inspector worked with the Program Manager of Resident Care to verify that applicable doors were alarmed and connected as prescribed. Documentation relating to monthly door alarm and registered nursing staff pager testing, as provided by the Program Manager of Resident Care, was reviewed. As well, the inspector and the Administrator reviewed a Critical Incident Report, relating to doors, and reviewed the home's emergency plans relating to loss of essential services.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

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

- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 9. (1)	CO #001	2015_330573_0005	133

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

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

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

On June 12th, 2015, the home's Program Manager of Resident Care, staff # S100, submitted a Critical Incident Report (CIR) to the Ministry of Health and Long Term Care to inform of a breakdown of the door security system. It was reported that on June 11th, 2015, door alarms that should activate when a door was open were not working. The CIR indicated that two security guards were in place to monitor the grounds outside of the home, and that they remained in place until June 17th, 2015.

On September 15th, 2015, inspector #133 began a Follow Up inspection at the home, related to a compliance order, pertaining to door alarms. The inspector and the Administrator met and discussed the CIR as a part of the Follow Up inspection. It was confirmed that it was the City of Ottawa Corporate Security's door monitoring system that had failed. The Administrator explained that the home discovered there was a problem with the door security system when they found a door that should have been locked was not, and then shortly thereafter, the door was locked again. The Administrator explained that both locks and alarms were affected. The Administrator confirmed that affected doors included resident accessible doors that lead to stairways, and resident accessible doors that lead to the outside of the home. The Administrator explained that when this was discovered, a phone call was placed to the City of Ottawa Corporate Security Centre, and the home was informed that there was a technical problem with the door security system in place at City of Ottawa buildings throughout the city, including the licensee's other long term care homes.

Inspector #133 had prior knowledge of the door security system failure affecting the licensee's long term care homes. A Critical Incident System inspection was conducted at the Peter D Clark Centre on September 2nd and 3rd, 2015 (#2015_346133_0035), with non-compliance issued in the area of emergency plans.

On September 15th, 2015, during discussion with the Administrator about the door security system failure at Carleton Lodge, the inspector asked if the actions taken to

ensure resident safety had been guided by a written emergency plan. The Administrator indicated that he requested two security guards to monitor the grounds, based on a risk assessment, considering factors such as the resident population at the time, and the weather (i.e. summer vs. winter). The Administrator explained that he had the guards circling the building, in opposite directions to one another. The Administrator indicated that he did not believe there was a written plan that provided for dealing with this situation. The Administrator and inspector looked through the home's emergency measures manual together, which contained all of the home's emergency plans. The Administrator explained that all of the City of Ottawa ltc homes have the same emergency plans, developed in the past by a Strategic Initiative Project Officer (SIPO), staff #S101, with the City of Ottawa Community and Social Services Department. It was noted that code grey included several plans that provide for dealing with the loss of essential services, such as the loss of elevators, the loss of the resident-staff communication and response system and the loss of the heating system. There were no written plans for dealing with the loss of safety and emergency equipment, which includes the door security system.

On September 21st, 2015, via email communication, a Security Adviser, staff # S102, with the Emergency and Protective Services Department of the City of Ottawa, confirmed for inspector #133 that between June 11th and June 15th, 2015, the doors at Carleton Lodge would have been locking/unlocking and the door alarms functioning intermittently. [s. 230. (2)]

Issued on this 22nd day of September, 2015

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

Original report signed by the inspector.