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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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Nov 13, 2018	2018_730593_0004 (A2) (Appeal\Dir#: DR# 097)	007822-18	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Carlingview Manor
2330 Carling Avenue OTTAWA ON K2B 7H1

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

Amended by Lynne Haves (Director) - (A2)(Appeal\Dir#: DR# 097)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

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NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector's order(s): CO#001.
The Director's review was completed on November 13, 2018.
Order(s) was/were rescinded and substituted with a Director Order to reflect the Director's review DR# 097.
A copy of the Director Order is attached.

Issued on this 13th day of November, 2018 (A2)(Appeal\Dir#: DR# 097)

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

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

Ministère de la Santé et des Soins de longue durée

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Amended by Lynne Haves (Director) - (A2)(Appeal/Dir# DR# 097)

Amended 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): April 17 - 20, May 1 - 2, 9, 14, 22, June 20, July 6, 11, 2018.

The following intakes were inspected during this inspection: Log #007900-18, CIS 2420-000027-18 alleged resident to resident abuse and Log #007822-18, CIS 2420-000030-18 reporting of an unexpected death.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Assistant Executive Director (AED), Acting Director of Care (DOC), Assistant Director of Care (ADOC), Senior Management from Corporate, Environmental Services Manager, Registered Nursing Staff, Maintenance Staff, Housekeeping Staff, Personal Support Workers (PSW) and residents.

The inspectors observed the provision of care and services to residents, staff to resident interactions, resident to resident interactions, residents' environment and reviewed resident health care records, recorded video footage, meeting minutes, staff training records and licensee policies.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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

4 WN(s)
0 VPC(s)
1 CO(s)
1 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. The licensee has failed to ensure that the home was a safe and secure

environment for resident #001.

A call was received from the long-term care home to the after hours Action Line to report an incident that resulted in the unexpected death of resident #001.

A critical incident report (CIS) was submitted by the LTC home to the Ministry of Health and Long-Term Care (MOHLTC), reporting that a deceased resident was found in the lower parking area by maintenance staff #109. After finding the resident, maintenance staff #109 reported the incident to the Executive Director (ED) #123 and the Assistant Executive Director (AED) #124. A code blue (medical emergency) was initiated at the LTC home and emergency services were called by staff member #121. The CIS documented that the resident's pulse was absent when discovered and that the police arrived within five minutes of the call and initiated an investigation. According to the CIS, PSW #102 found the window opened in resident #001's room and called the housekeeper to secure the windows which had been found on the floor. It was reported in the CIS that there was camera footage which showed resident #001 falling from the floor D window.

Resident #001 was elderly and had been a resident at the home for several years. During the resident's stay at the LTC home, the resident resided mostly on floor A. However the resident was moved to floor B in 2017. Resident #001 was then moved to floor C, early 2018 and then to floor D several months later.

The LTC home has a security camera facing the parking area at the back of the home (rear entrance). The footage recorded the morning of resident #001's death was reviewed by Inspectors #593 and #655. It was observed that the resident fell from the window head first before hitting the ground.

The LTC home has a security camera in the west corridor of the building on floor D. The view was from above the elevators facing the west corridor and the entrance to resident #001's room could be seen. The footage recorded the morning of resident #001's death was viewed by Inspectors #593 and #655. Resident #001 was observed to enter their room. One minute and 50 seconds later, the resident was seen falling from a floor D window on the outside security camera. No staff or residents were observed to be near, entering or exiting their room during the time of the incident.

The following was observed at the LTC home, the day of resident #001's death by Inspectors #593 and #655:

1445 hours: The left side window located in resident #001's room which was the window resident #001 removed and subsequently fell from. Further observed was a larger upper window pane which did not open to the outdoors. Below the larger window, there was a horizontal slider style window. In the horizontal slider style window, two panels operated by sliding along a track in the window frame. The panels were held in place by the track and window frame. At the time of the observation, the placement of additional screws had been completed at the top of the window panel in the horizontal slider style window, preventing the panel on this window from being lifted up and away from the window track and frame. In between the two sliding windows, there was a screen. This was secured in place at the time of the observations.

1455 hours: The right side window in another room, where Inspector #593 was able to remove one panel from the window track and frame. There was a screw in place along the track of the window, intended to prevent the window panel from sliding along the track to a point that would create an opening exceeding a specified dimension (10 centimeters or four inches). With those screws in place, Inspector #593 was able to lift the panel up without the use of significant force and away from the track and window frame, removing the panel entirely. During the inspection, all slider style windows within the home were bolted shut the same day of the incident by the LTC home. The window was observed before this had been completed.

Inspectors #593 and #655 reviewed resident #001's documented plan of care and found that the resident exhibited responsive behaviours including elopement, with a goal documented to have decreased episodes of exit seeking behaviour. Documented interventions included safety checks every one hour, observations for exit seeking behaviours and a roam alert sensor applied in 2017.

A review of resident #001's progress notes by Inspectors #593 and #655, indicated a pattern of agitated and exit seeking behaviour in the nine days prior to their death, the following is a summary of the progress notes:

• Day 1, 1406 hours- It was charted by PSW #118 that resident #001 was very agitated in the morning. Resident #001 had packed and taken some of their things to resident #002's room where they spent most of the shift.

• Day 2, 1330 hours- It was charted by ADOC #115 that resident #001 was

visiting with resident #002 in their room. They had developed a friendship. Resident #002 gave resident #001 their coat and resident #001 had been attempting to move items from their room into resident #002's room.

• Day 2, 1356 hours- It was charted by RPN #116 that the Substitute Decision Maker (SDM) for resident #001 was called by staff and made aware of resident #001's behaviours. The SDM was notified that resident #001 would be moving to floor D.

• Day 2, 1523 hours- It was charted by ADOC #115 that resident #001 was frustrated with the move to floor D. Resident #001 had been exhibiting responsive behaviours around the elevator. Huddles were held with staff on the floor to ensure high alert monitoring was in place.

• Day 2, 2220 hours- Exit seeking noted by RPN #128.

• Day 4, 1151 hours- Resident #001 said "I want to look for my friends", "can I go downstairs?" Resident #001 was asking to leave the unit to go down stairs to look for their friends. It was documented by RPN #107 that resident #001 required supervision from staff to ensure whereabouts, was at risk for exit seeking and staff were to continue to monitor resident #001's whereabouts.

• Day 5, 1300 hours- It was charted by RPN #107 that resident #001 was arguing and stated "I want to go look for my friend". Staff were trying to distract the resident but they were trying to exit on the elevator to look for their friend and arguing with staff because they couldn't leave the unit. It was documented that resident #001 was at risk for elopement and staff were to continue to monitor their whereabouts and behaviour.

• Day 5, 1506 hours- It was charted by RPN #107 that resident #001 was observed walking in the hallway stating "I want to go to floor C to see resident #002". Resident #001 was returned to the unit by recreation staff and the charge nurse, resident #001 did not want to return to floor D. Resident #001 eventually came off the elevator and wanted to call their sister. Recreation staff dialed resident #001's sister and then resident #001 came off the telephone and was taken to their room by recreation staff and later, resident #001 was in the lounge talking about going to floor C. It was documented that resident #001 was at risk for elopement and staff were to continue to monitor resident #001's whereabouts.

• Day 5, 1549 hours- Resident #001 was saying "I want to see resident #002." Resident #001 was agitated because they had been separated from their "friend". It was explained to the resident by staff member #129 that they did not have a key to the elevator, and resident #001 became even more agitated.

• Day 5, 2232 hours- It was charted by RPN #130 that a co-resident pulled the fire alarm at 1815 hours, the stairs on zone A were opened and resident #001 ambulated to the door to exit. Two staff members and two PSW students stopped the resident immediately. The charge RN came to the unit immediately and the on call physician was contacted. Resident #001 was given a particular medication at 1605 hours. At 1900 hours, the physician called the home and several orders were received.
Resident #001's SDM was called to obtain consent for the administration of the newly prescribed drug regimen. Resident #001 was administered all medications, including PRN and scheduled HS medications. Resident #001 became calm, went to their room to rest. The particular medication PRN was given at 1906 hours as per STAT order, with minimal effect. Another PRN of the same medication was given at 2012 hours with good effect.

• Day 5, 2310 hours- The charge RN #127 responded to a call on the unit approximately 1830 hours and upon arrival, the RPN on the unit reported that resident #001 had tried to exit the zone A exit door on the unit while the fire alarm was going off. Resident #001 stated that they were going to floor C to be with their friend and staff had intervened to prevent the resident going into the stairwell. Resident #001 was alert but very agitated on the unit, talking out loud and verbalizing their desire to go to floor C. The RN discussed with the RPN about resident #001's status, and advised to contact the physician on call for medications, as needed. Resident #001 settled in bed as the medication given as per the order was effective.

• Day 6, 2148 hours- Exit seeking noted by RPN #128. Resident #001 continued to ask to go to floor C to see their friend. Redirected with little effect. It was documented that the staff would continue to monitor.

• Day 7, 1437 hours- It was charted by RPN #131 that resident #001 was exit seeking this shift in the morning, inquiring how to get to floor C to meet with their friend. Resident #001 was easily redirected.

• Day 7, 2145 hours- Behavior monitoring continued. Exit seeking noted at times

by RPN #128 on this shift. Resident #001 was found in resident #002's room on floor C around 1640 hours and was guided back to floor D. Resident #001 was given a specific medication as a PRN. Resident #001 was under close monitoring since then. It was documented by RPN #128 that the staff would continue to monitor their behavior.

• Day 8, 0628 hours- Behaviour monitoring was initiated every shift for seven days which included monitoring and documenting responsive behaviours. It was documented by RN #132 to ensure that PSW's were completing the behaviour mapping charting.

A review of resident #001's plan of care by Inspector #593 and #655 for the same month of resident #001's death, found the following orders and medication administration records (MAR):

• Behaviour monitoring every shift for one week. Every shift for seven days until finished. Monitor and document responsive behaviours. Ensure PSW's complete behaviour mapping charting. Start date: Day 1 at 1500 hours.
o This was charted as completed starting day 1 evening shift (1500 - 2300 hours) until day 7 day shift (0700 - 1500 hours).

• Monitor resident hourly for seven days for exit seeking. Every shift for safety. Start date: Day 1, discontinued date: Day 4 at 1121 hours.
o This was charted as completed starting day 1 night shift (2300 - 0700 hours) until day 4 day shift (0700 - 1500 hours).

• Resident safety review (Nurse). Elopement risk, behaviours. Discontinued date: Day 9 at 2300 hours.
o This was charted as completed from day 1 day shift (0700 - 1500 hours) until day 9 evening shift (1500 - 2300 hours).

• Monitor resident hourly for seven days for exit seeking. Every hour for safety for seven days until finished. Start date: Day 1 at 1200 hours.
o This was charted as completed hourly starting day 2 at 2400 hours until day 8 at 0700 hours.

The following directions and task completion documentation were found in the point of care (POC) system:

• Resident safety monitoring. Elopement risk. Monitor whereabouts every hour.
This was charted as completed for the following times:
Day 1, 2018 0030 hours – Day 4, 2018 0330 hours
Day 4, 2018 0730 hours – Day 13, 2018 1430 hours
Day 14, 2018 0730 hours – Day 14, 2018 2200 hours
Day 14, 2018 0730 hours – Day 17, 2018 0730 hours

During an interview with Inspectors #593 and #655 April 19, 2018 at 1132 hours, PSW #100 who regularly worked on floor D and was working on floor D at the time of resident #001's death, reported that resident #001 had exit seeking behaviours related to wanting to see their friend on floor C. PSW #100 added that resident #001 was probably exit seeking the morning of their death, as the resident was walking continuously throughout the unit. PSW #100 confirmed that the resident was on hourly safety checks but the last time they saw the resident was during shift report, which was just after 0700 hours.

During an interview with Inspectors #593 and #655 April 19, 2018 at 1230 hours, PSW #101 who regularly worked on floor D and was working on floor D at the time of resident #001's death, reported that resident #001's behaviour was mostly related to wanting to be out of the unit.

During an interview with Inspectors #593 and #655 April 19, 2018 at 1330 hours, PSW #102, the PSW assigned to resident #001 the day of their death, reported that resident #001 wanted to leave the unit. Resident #001 had only been on floor D a couple of weeks, and mostly wanted to leave the unit. Resident #001's focus was that they wanted to leave, to go home, as they were on floor C previously. PSW #102 further reported that at 0800 hours, the day of resident #001's death, they entered resident #001's room and found it really cold. The PSW found the window panels down, both interior and exterior windows as well as the screen. PSW #102 told the housekeeper and the housekeeper called for maintenance to fix the window. PSW #102 went to provide care for another resident in the same room until 0830 hours and reported that they did not see resident #001 during this time and by 0830 hours, the window had been fixed. PSW #102 reported that the resident was on hourly safety and monitoring checks which started at 0730 hours on the day shift. PSW #102 reported that they completed the safety check at 0730 hours, but did not complete the check at 0830 hours as they did not see the resident. PSW #102 said that if they did not see resident #001, they are supposed to actively look for the resident. However as 0830 hours is breakfast time, the resident would usually be in the dining room and the PSW was providing care for

other residents at this time.

During an interview with Inspectors #593 and #655 April 20, 2018 at 0940 hours, PSW #105, who was working on floor D, the day of resident #001's death and reported that resident #001 set off the fire alarm last week and was able to reach floor C to see resident #002. PSW #105 reported that they were not aware of any safety and monitoring checks for resident #001.

During an interview with Inspectors #593 and #655 April 20, 2018 at 1020 hours, PSW #106, who was working on floor D the day of resident #001's death, reported that resident #001 just wanted to go, mostly to floor C to see their friend and that they had attempted to exit the unit many times previously via the elevator. PSW #106 further reported that resident #001 was on safety and monitoring checks and it was the responsibility of all staff to watch the resident so that they did not leave the unit.

During an interview with Inspectors #593 and #655 May 01, 2018 at 1039 hours, PSW #111, who worked regularly on floor C reported that when resident #001 was on floor C, the resident would say "I want to escape, it's like I am in jail" however they did not know of the resident actually trying to leave floor C.

During an interview with Inspectors #593 and #655, May 02, 2018 at 0708 hours, PSW #114, who worked the night shift on floor D finishing at 0700 hours the day of resident #001's death, reported that they provided care for resident #001 during this shift, however they were not aware of any safety and monitoring checks for this resident.

During an interview with Inspectors #593 and #655 April 20, 2018 at 1100 hours, RPN #107, who was the regular dayshift RPN on floor D, reported that resident #001 had behaviours related to wandering and wanting to leave the unit. Resident #001 had attempted to leave the unit previously via the elevator and if staff tried to stop the resident, they became angry. RPN #107 further indicated that the resident exited the unit several days earlier, and they were not sure how they exited, but the resident was returned safely to floor D. RPN #107 confirmed that resident #001 was on safety and monitoring checks for exit seeking.

During an interview with Inspectors #593 and #655 May 01, 2018 at 1200 hours, RN #113, who was the regular dayshift RN on floors C and D, reported that resident #001 had exit seeking behaviours including asking for the elevator key,

trying to leave on the elevators with staff or visitors and talking about going to floor C to visit resident #002. The behaviours had been present for quite awhile but had worsened recently when the resident was moved to floor C, and again after the move to floor D. Resident #001 had a wander guard bracelet for this reason and was also on safety monitoring after the move to floor D. RN #113 indicated that resident #001 had a successful exit once that they knew of, where resident #001 made it to floor C.

During an interview with Inspectors #593 and #655 May 9, 2018 at 1046 hours, Maintenance staff #119 reported that they fixed the window in resident #001's room before there was knowledge of the incident occurring. Staff member #119 further reported that both interior and exterior windows were out of the window frames and the screen was bent. They added that the windows were removed by housekeeping for cleaning especially on floors C and D as they received more of the lint blown up from the laundry exhaust fan as they were the levels of the home that were closer to the laundry.

During an interview with Inspectors #593 and #655 May 22, 2018 at 1033 hours, Maintenance staff #125 reported that they were the person that looked after the preventative maintenance (PM) in the home and had been in that role for at least two years. Maintenance staff #125 further reported that they were aware that housekeeping staff previously removed windows for cleaning, as after some of the windows were removed from the frames, they needed maintenance staff to get them back in the window frame. They added that the window track was supposed to be pressed down by some rubbers but they were gone, so the track could be crooked and the housekeeping staff did not know how to push it back. They confirmed that the housekeeping staff did not need any tools to remove the windows from the tracks. Maintenance staff member #125 reported that there used to be PM on the windows which was completed when the room was vacated and in preparation for a new resident. There was a check sheet that they completed which included checking that the windows did not open more than 10 centimetres or four inches and that the screens were intact but they do not have that anymore and it has been at least two years since they had used this checksheet.

During an interview with Inspectors #593 and #655 April 20, 2018 at 1257 hours, housekeeping staff #110 reported that they were the regular housekeeper for floor D. The morning of resident #001's death, PSW #102 approached housekeeping staff #110 and told them that the window was open and to phone maintenance.

When housekeeping staff #110 entered resident #001's room, and observed that the windows were opened, they called the maintenance department. Maintenance staff #119 arrived within 5-10 minutes and secured the windows. Housekeeping staff #110 reported that resident #001 told them previously that they wanted to see their friend who was on floor C and that they had also seen the resident trying to get onto the elevators.

During a second interview with Inspectors #593 and #655, May 22, 2018 at 0933 hours, housekeeping staff #110 reported that until recently, they would remove the inner windows from the tracks to clean them and they did not require any tools to remove the windows. Some of the windows were easy to remove however sometimes they needed to call maintenance to help put them back in the window frames. Housekeeping staff #110 added that the windows on floors C and D would get more of a buildup of dust due to being closer to the dryer vents from the laundry. The windows would usually be cleaned during the deep cleans and sometimes residents would still be in the room when these cleans were taking place. The outer surface of the exterior window panel was cleaned twice a year by a contractor; whereas the interior window panel was being removed from the window frame more often, as needed, when they were observed to be unclean, by housekeeping.

During an interview with Inspectors #593 and #655 May 14, 2018 at 1044 hours, Housekeeping staff #122, who was the regular housekeeper for floor C reported that until recently when the windows were bolted shut, they would remove windows out of the window frames to clean them completely, at least once per year. They would remove both the interior and exterior windows, wash each window and the window tracks. The housekeeping staff did not need any tools to remove the windows, however sometimes the tracks would jam and they needed to call maintenance to put the windows back in. The windows were old, they needed to be replaced, reported housekeeping staff #122 and when the windows were cleaned as part of the deep clean, they would try to ensure that the resident was not in the room but this was not always possible.

During an interview with Inspectors #593 and #655 May 2, 2018 at 1000 hours, ADOC #115 reported that resident #001 was exit seeking on both floors C and D. ADOC #115 further reported that resident #001 was on safety and monitoring checks at the time of their death which was supposed to be hourly. They indicated that the LTC home were definitely keeping a close eye on the resident after their most recent move.

During an interview with Inspectors #593 and #655 May 9, 2018 at 1302 hours, Environmental Services Manager (ESM) #120 reported that after the incident resulting in resident #001's death, the Environmental Services department were directed by the licensee to secure the windows. They had an interim fix which involved bolting the windows shut however the permanent solution was to fix the moveable upper track as every window had a fixed lower track and a moveable upper track. The moveable upper track was there to facilitate, or make it easier to remove the window for cleaning. They pushed the upper track down, added three screws to fix it in place, so that the window could not be pushed up and taken out of the window frame. The ESM further reported that there were checks on the windows from maintenance staff which included checking the windows and screens for cleanliness and checking to ensure the window did not open more than four inches. These checks were to happen quarterly however this was not documented as the preventative maintenance (PM) was received on maintenance staff's iPods, and when staff completed the check, the PM was closed online and no longer visible.

During an interview with Inspectors #593 and #655 May 22, 2018 at 1051 hours, Executive Director (ED) #123 reported that resident #001 was on hourly safety checks and on the hour, the resident was to be observed. If the resident could not be located, a code yellow (missing resident) should be called. The ED added that there were quarterly preventative maintenance checks on the windows which involved checking that the limiter screw was in place and that the windows were not falling out of the frame and that they were in good repair. The ED confirmed that there was a policy in place related to the PM checks for windows.

A review of the home's policy from the environmental services manual "Maintenance Department, Subject: Windows" Index I.D. ES E-75-20 dated December 1, 2017, found that the ESM or designate was required to inspect the windows on a monthly basis. The policy further documented to check all windows to ensure that they had a screen that was in good repair and that the seals were in good condition with no leakage. The policy also required that all window locks and latches were in good repair and check all windows to ensure that they did not open more than 10 centimeters or four inches.

Resident #001 had a history of exit seeking behaviours which increased after the move to floor D. Shortly after the move to floor D, resident #001 was able to physically remove two window panels and one screen from the window frame of a

floor D window and following this, resident #001 fell to their death. The licensee knew that windows at the LTC home were easily removed from the tracks when they were being cleaned by staff in the LTC home. In addition, staff at the LTC home were aware that resident #001 was exhibiting specific exit seeking behaviours which required the resident's frequent monitoring. As such, the licensee has failed to ensure that the home was a safe and secure environment for resident #001. [s. 5.]

Additional Required Actions:

(A2)(Appeal/Dir# DR# 097)
The following order(s) have been rescinded: CO# 001

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care for resident #001 was provided to the resident as specified in the plan.

A critical incident report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC). The report indicated that a deceased resident was found in the lower parking area by maintenance staff member #109. After being found, maintenance staff member #109 reported the incident to the Executive Director (ED) #123 and the Assistant Executive Director (AED) #124. A code blue was initiated and emergency services were called by staff member #121. The CIS documented that the resident's pulse was absent when discovered and that the police arrived within five minutes and initiated an investigation. According to the CIS, PSW #102 found the window opened in resident #001's room and called the housekeeper to secure the windows which had been found on the floor. It was reported in the CIS that there was camera footage where resident #001 was seen falling out of the window from floor D.

Inspectors #593 and #655 reviewed the health care record belonging to resident #001.

In resident #001's documented plan of care, resident #001 was identified as having responsive behaviours, including exit-seeking behaviours with a history of elopement. According to the same care plan, staff were to conduct "safety checks" every one hour for resident #001; and, were to observe for exit-seeking behaviours. According to the documented plan of care, resident #001 was also to have a roam alert sensor applied.

In the progress notes, resident #001 was again identified as being at risk for elopement. The need for the monitoring of resident #001's whereabouts by staff was also identified in the progress notes.

Inspector #655 reviewed the Point of Care documentation for the month of resident #001's death; specifically for the task "Resident Safety Monitoring. Elopement risk. Monitor whereabouts every hour". There were no entries made for the following dates and times before the day of resident #001's death:
- Day 4, between 0430 and 0630 hours,
- Day 13, between 1530 hours and 2330 hours; and,
- Day 14, between 0030 and 0630.

The documentation for the day of resident #001's death, is indicative that this monitoring was done hourly between the hours of 0030 and 0730. However, there was no entry found for 0830 hours.

During an interview on April 19, 2018, PSW #102 indicated to Inspectors #593 and #655 that they had been assigned to care for resident #001 the day of their death. PSW #102 described resident #001 as "actively mobile", and wanting to leave. PSW #102 further indicated to the inspectors that resident #001 was on hourly safety and monitoring checks at the time of the incident. PSW #102 recalled that on the day of resident #001's death, they completed the safety check for resident #001 at 0730 hours; and at 0800 hours the same day, they had entered resident #001's room to find that both of the window panels were "down", as well as the screen. Resident #001 was not in the room at the time. PSW #102 indicated to the inspectors that they then proceeded to provide care to other residents until 0830 hours. During the same interview, PSW #102 indicated to the inspectors that they had not completed the 0830 hour check the day of resident #001's death, because they did not see resident #001 at the time. PSW #102 further indicated that they had not actively looked for the resident when they were not found at 0830 hours because they expected that the resident was in the dining room for breakfast at that time and because they had been providing care to the other residents.

Resident #001 fell from a window in their room that morning, and was found outside by maintenance staff #109, deceased.

The licensee failed to ensure that the care set out in the plan of care for resident #001 was provided to the resident as specified in the plan when the hourly safety check was not completed for resident #001 at 0830 hours on the day of their death. [s. 6. (7)]

2. The licensee failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised when the care set out in the plan of care had not been effective.

Inspectors #593 and #655 reviewed the health care record belonging to resident #001.

In resident #001's documented plan of care, resident #001 was identified as having responsive behaviours, including exit-seeking behaviours with a history of

elopement. According to the same documented plan of care, staff were to conduct "safety checks" every one hour for resident #001; and, were to observe for exit-seeking behaviours. According to the documented plan of care, resident #001 was also to have a roam alert sensor applied to the left ankle.

According to the progress notes in resident #001's health care record, resident #001 had exhibited exit-seeking behaviours on for different days during the nine days prior to their death. According to a progress note entered at 1645 hours on day 14, by RN #127, resident #001 was found at approximately 1600 hours that day to be on another resident home area, on floor C. According to the same note, resident #001 had gone to floor C to visit with a "resident friend". On the same day, RPN #128 wrote in a progress note entered at 2145 hours that resident #001 was found at approximately 1640 hours to be in resident #002's room on floor C.

Over the course of the inspection, Inspectors #593 and #655 interviewed several staff members who identified resident #001 as having exit-seeking behaviours (PSW #100, #101, #106, #111). During an interview on April 19, 2018, PSW #102 further described resident #001 as "actively mobile".

None of the staff members who were interviewed during the inspection were able to speak to how resident #001 was able to exit their resident home area (on floor D) to get to floor C on day 14, as described in the above-listed progress note.

Inspector #655 reviewed the Point of Care documentation for the month of resident #001's death, specifically for the task "Resident Safety Monitoring. Elopement risk. Monitor whereabouts every hour". The documentation for day 14 is indicative that this monitoring was done hourly between the hours of 0720 and 2330.

Inspector #655 also reviewed the Medication Administration Record (MAR) belonging to resident #001 for the month of resident #001's death. According to the MAR, resident #001 was to be monitored every one hour for seven days for exit seeking and every hour for safety for seven days, starting on day 13. The documentation on the MAR is indicative that this monitoring was done hourly on day 14.

On June 8, 2018, Executive Director #123 indicated to Inspector #655 that on day 14, resident #001 was able to leave their resident home area through a stairwell door during a fire drill. There are no roam alert sensors located at stairwell doors

in the home.

Over the course of the inspection, the inspectors found no evidence that would be indicative that the hourly monitoring of resident #001 had been reviewed or revised when the intervention was not effective on day 14.

The licensee failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised when the care set out in the plan of care had not been effective.

CO # - 001 will be served on the licensee. Refer to "Order (s) of the Inspector". [s. 6. (10) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's procedure, part of the environmental services manual "Maintenance Department, Subject: Windows" Index I.D. ES E-75-20 dated December 1, 2017, was complied with.

In accordance with s.90 (1) b of O.Reg 79/10, the licensee was required to have procedures in place for routine, preventative and remedial maintenance as part of

the organized maintenance program.

A critical incident report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), reporting that a deceased resident was discovered in the lower parking area by maintenance staff member #109. After discovery, maintenance staff member #109 reported the incident to the Executive Director (ED) #123 and the Assistant Executive Director (AED) #124. A code blue was initiated and emergency services were called by staff member #121. According to the CIS, PSW #102 found the window opened in resident #001's room and called the housekeeper to secure the windows which had been found on the floor. It was reported in the CIS that there was camera footage where resident #001 was seen falling from the floor D window.

The following was observed the day of resident #001's death by Inspectors #593 and #655:

1455 hours: The right side window in resident #001's room, where Inspector #593 was able to remove one panel from the window track and frame. There was a screw in place along the track of the window, intended to prevent the window panel from sliding along the track to a point that would create an opening exceeding a specified dimension (10 centimeters or four inches). With those screws in place, Inspector #593 was able to lift the panel up without the use of force and away from the track and window frame, removing the panel entirely. As a result of the CIS, all slider style windows within the home were bolted shut the same day of the incident. This window was observed before this had been completed.

During an interview with Inspectors #593 and #655 April 19, 2018 at 1330 hours, PSW #102, reported that on the day of resident #001's death, they entered resident #001's room and found it really cold. The PSW found the window panels down, both interior and exterior windows as well as the screen. PSW #102 told the housekeeper and the housekeeper called for maintenance to fix the window.

During an interview with Inspectors #593 and #655 May 22, 2018 at 1033 hours, Maintenance staff #125 reported that they were the person that looked after the preventative maintenance (PM) in the home and had been in that role for at least two years. Maintenance staff #125 further reported that they were aware that housekeeping staff previously removed windows for cleaning, as after some of the windows were removed from the frames, they needed maintenance staff to get

them back in the window frame. They added that the window track was supposed to be pressed down by some rubbers but they were gone, so the track could be crooked and the housekeeping staff did not know how to push it back. They confirmed that the housekeeping staff did not need any tools to remove the windows from the tracks. Maintenance staff member #125 reported that there used to be PM on the windows which was completed when the room was vacated and in preparation for a new resident. There was a check sheet that they completed which included checking that the windows did not open more than 10 centimetres or four inches and that the screens were intact but they do not have that anymore and it has been at least two years since they had used this checksheet.

During an interview with Inspectors #593 and #655 May 22, 2018 at 0933 hours, Housekeeping staff #110 reported that they were the regular housekeeper for floor D and that until recently, they would remove the inner windows from the tracks to clean them and they did not require any tools to do so. Some of the windows were easy to remove however sometimes they needed to call maintenance to help insert them back in the window frames. Housekeeping staff #110 added that the windows on floors C and D would get more of a buildup of dust due to being closer to the dryer vents from the laundry. The windows would usually be cleaned during the deep cleans and sometimes residents would still be in the room when these cleans were taking place. The outer surface of the exterior window panel was cleaned twice a year by a contractor; whereas the interior window panel was being removed from the window frame more often, as needed, when they were observed to be unclean, by housekeeping.

During an interview with Inspectors #593 and #655 May 14, 2018 at 1044 hours, Housekeeping staff #122, who was the regular housekeeper for floor C reported that until recently when the windows were bolted shut, they would remove windows out of the window frames to clean them completely, at least once per year. They would remove both the interior and exterior windows, wash each window and the window tracks. The housekeeping staff did not need any tools to remove the windows, however sometimes the tracks would jam and they needed to call maintenance to put the windows back in. The windows were old, they needed to be replaced, reported housekeeping staff #122 and when the windows were cleaned as part of the deep clean, they would try to ensure that the resident was not in the room but this was not always possible.

During an interview with Inspectors #593 and #655 May 9, 2018 at 1302 hours,

Environmental Services Manager (ESM) #120 reported that after the incident resulting in resident #001's death, the Environmental Services department were directed by the licensee to secure the windows. They had an interim fix which involved bolting the windows shut however the permanent solution was to fix the moveable upper track as every window had a fixed lower track and a moveable upper track. The moveable upper track was there to facilitate, or make it easier to remove the window for cleaning. They pushed the upper track down, added three screws to fix it in place, so that the window could not be pushed up and taken out of the window frame. The ESM further reported that there were checks on the windows from maintenance staff which included checking the windows and screens for cleanliness and checking to ensure the window did not open more than four inches. These checks were to happen quarterly however this was not documented as the PM was received on maintenance staff's iPods, and when staff completed the check, the PM was closed online.

During an interview with Inspectors #593 and #655 May 22, 2018 at 1051 hours, Executive Director (ED) #123 reported that there were quarterly preventative maintenance checks on the windows which involved checking that the limiter screw was in place and that the windows were not falling out of the frame and that they were in good repair. The ED confirmed that there was a procedure in place related to the PM checks for windows.

A review of the home's procedure, part of the environmental services manual "Maintenance Department, Subject: Windows" Index I.D. ES E-75-20 dated December 1, 2017, found that the ESM or designate was required to inspect the windows on a monthly basis. The policy further documented to check all windows to ensure that they had a screen that was in good repair and that the seals were in good condition with no leakage. Ensure all window locks and latches were in good repair and check all windows to ensure that they did not open more than 10 centimeters or four inches.

Resident #001 was able to physically remove two window panels and one screen from the window frame of a floor D window where resident #001 fell to their death. It was acknowledged by staff that windows were easily removed from the tracks for cleaning, with staff reporting that PM was not completed regularly on the windows as per the procedure.

CO # - 001 will be served on the licensee. Refer to "Order (s) of the Inspector". [s. 8. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimetres.

A call was received from the long-term care (LTC) home to the after hours Action Line to report an incident that resulted in the unexpected death of resident #001. The call indicated that resident #001 jumped out of a floor D window of the LTC home and died.

A critical incident report (CIS) was submitted by the LTC home to the Ministry of Health and Long-Term Care (MOHLTC), reporting that a deceased resident was found in the lower parking area by maintenance staff #109. According to the CIS, PSW #102 found the window opened in resident #001's room and called the housekeeper to secure the windows which had been found on the floor. It was reported in the CIS that there was camera footage which showed resident #001 falling from the floor D window.

The following was observed at the LTC home, the day of resident #001's death by Inspectors #593 and #655:

1445 hours: The left side window located in resident #001's room, which was the window resident #001 removed and subsequently fell from. Further observed was a larger upper window pane which did not open to the outdoors. Below the larger

window, there was a horizontal slider style window. In the horizontal slider style window, two panels operated by sliding along a track in the window frame. The panels were held in place by the track and window frame. At the time of the observation, the placement of additional screws had been completed at the top of the window panel in the horizontal slider style window, preventing the panel on this window from being lifted up and away from the window track and frame. In between the two sliding windows, there was a screen. This was secured in place at the time of the observations.

1455 hours: The right side window in another room on floor D, where Inspector #593 was able to remove one panel from the window track and frame. There was a screw in place along the track of the window, intended to prevent the window panel from sliding along the track to a point that would create an opening exceeding a specified dimension (10 centimeters or four inches). With those screws in place, Inspector #593 was able to lift the panel up without the use of significant force and away from the track and window frame, removing the panel entirely. During the inspection, all slider style windows within the home were bolted shut the same day of the incident by the LTC home. The window was observed before this had been completed.

During an interview with Inspectors #593 and #655 April 19, 2018 at 1330 hours, PSW #102, the PSW assigned to resident #001 the day of their death, reported that at 0800 hours, the day of resident #001's death, they entered resident #001's room and found it really cold. The PSW found the window panels down, both interior and exterior windows as well as the screen. PSW #102 told the housekeeper and the housekeeper called for maintenance to fix the window. PSW #102 went to provide care for another resident in the same room until 0830 hours and reported that they did not see resident #001 during this time and by 0830 hours, the window had been fixed.

During an interview with Inspectors #593 and #655 May 9, 2018 at 1046 hours, Maintenance staff #119 reported that they fixed the window in resident #001's room before there was knowledge of the incident occurring. Staff member #119 further reported that both interior and exterior windows were out of the window frames and the screen was bent. They added that the windows were removed by housekeeping for cleaning especially on floors C and D as they received more of the lint blown up from the laundry exhaust fan as they were the levels of the home, closer to the laundry.

During an interview with Inspectors #593 and #655 May 22, 2018 at 1033 hours, Maintenance staff #125 reported that they were the person that looked after the preventative maintenance (PM) in the home and had been in that role for at least two years. Maintenance staff #125 further reported that they were aware that housekeeping staff previously removed windows for cleaning, as after some of the windows were removed from the frames, they needed maintenance staff to get them back in the window frame. They added that the window track was supposed to be pressed down by some rubbers but they were gone, so the track could be crooked and the housekeeping staff did not know how to push it back. They confirmed that the housekeeping staff did not need any tools to remove the windows from the tracks. Maintenance staff member #125 reported that there used to be PM on the windows which was completed when the room was vacated and in preparation for a new resident. There was a check sheet that they completed which included checking that the windows did not open more than 10 centimetres or four inches and that the screens were intact but they do not have that anymore and it has been at least two years since they had used this checksheet.

During an interview with Inspectors #593 and #655 April 20, 2018 at 1257 hours, housekeeping staff #110 reported that they were the regular housekeeper for floor D. The morning of resident #001's death, PSW #102 approached housekeeping staff #110 and told them that the window was open and to phone maintenance. When housekeeping staff #110 entered resident #001's room, and observed that the windows were opened, they called the maintenance department. Maintenance staff #119 arrived within 5-10 minutes and secured the windows. Housekeeping staff #110 reported that resident #001 told them previously that they wanted to see their friend who was on the second floor and that they had also seen the resident trying to get onto the elevators.

During a second interview with Inspectors #593 and #655, May 22, 2018 at 0933 hours, housekeeping staff #110 reported that until recently, they would remove the inner windows from the tracks to clean them and they did not require any tools to remove the windows. Some of the windows were easy to remove however sometimes they needed to call maintenance to help put them back in the window frames. Housekeeping staff #110 added that the windows on floors C and D would get more of a buildup of dust due to being closer to the dryer vents from the laundry. The windows would usually be cleaned during the deep cleans and sometimes residents would still be in the room when these cleans were taking place. The outer surface of the exterior window panel was cleaned twice a year by

a contractor; whereas the interior window panel was being removed from the window frame more often, as needed, when they were observed to be unclean, by housekeeping.

During an interview with Inspectors #593 and #655 May 14, 2018 at 1044 hours, Housekeeping staff #122, who was the regular housekeeper for floor C reported that until recently when the windows were bolted shut, they would remove windows out of the window frames to clean them completely, at least once per year. They would remove both the interior and exterior windows, wash each window and the window tracks. The housekeeping staff did not need any tools to remove the windows, however sometimes the tracks would jam and they needed to call maintenance to put the windows back in. The windows were old, they needed to be replaced, reported housekeeping staff #122 and when the windows were cleaned as part of the deep clean, they would try to ensure that the resident was not in the room but this was not always possible.

During an interview with Inspectors #593 and #655 May 9, 2018 at 1302 hours, Environmental Services Manager (ESM) #120 reported that after the incident resulting in resident #001's death, the Environmental Services department were directed by the licensee to secure the windows. They had an interim fix which involved bolting the windows shut however the permanent solution was to fix the moveable upper track as every window had a fixed lower track and a moveable upper track. The moveable upper track was there to facilitate, or make it easier to remove the window for cleaning. They pushed the upper track down, added three screws to fix it in place, so that the window could not be pushed up and taken out of the window frame. The ESM further reported that there were checks on the windows from maintenance staff which included checking the windows and screens for cleanliness and checking to ensure the window did not open more than four inches. These checks were to happen quarterly however this was not documented as the preventative maintenance (PM) was received on maintenance staff's iPods, and when staff completed the check, the PM was closed online and no longer visible.

During an interview with Inspectors #593 and #655 May 22, 2018 at 1051 hours, Executive Director (ED) #123 reported that there were quarterly preventative maintenance checks on the windows which involved checking that the limiter screw was in place and that the windows were not falling out of the frame and that they were in good repair. The ED confirmed that there was a policy in place related to the PM checks for windows.

Resident #001 was able to physically remove two window panels and one screen from the window frame of a floor D window where resident #001 fell to their death. It was acknowledged by staff that windows were easily removed from the tracks for cleaning, with staff reporting that PM was not completed regularly on the windows as per the policy. As such, the licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents could not be opened more than 15 centimetres.

CO # - 001 will be served on the licensee. Refer to "Order (s) of the Inspector". [s. 16.]

Issued on this 13th day of November, 2018 (A2)(Appeal/Dir# DR# 097)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by Lynne Haves (Director) - (A2) (Appeal/Dir# DR# 097)
Inspection No. / No de l'inspection :	2018_730593_0004 (A2)(Appeal/Dir# DR# 097)
Appeal/Dir# / Appel/Dir#:	DR# 097 (A2)
Log No. / No de registre :	007822-18 (A2)(Appeal/Dir# DR# 097)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 13, 2018(A2)(Appeal/Dir# DR# 097)
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4
LTC Home / Foyer de SLD :	Carlingview Manor 2330 Carling Avenue, OTTAWA, ON, K2B-7H1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Matt Carroll

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

To Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

(A2)(Appeal/Dir# DR# 097)
The following Order(s) have been rescinded:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Linked to Existing Order/ Lien vers ordre existant :

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.

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 13th day of November, 2018 (A2)(Appeal/Dir# DR# 097)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by Lynne Haves (Director) - (A2)
(Appeal/Dir# DR# 097)

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

Ministry of Health and Long-Term Care
Long-Term Care Homes Division
Long-Term Care Inspections Branch

Ministère de la Santé et des Soins de longue durée
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	☐ **Licensee Copy/Copie du Titulaire** ✕ **Public Copy/Copie Public**
Name of Director:	Lynne Haves
Order Type:	☐ Amend or Impose Conditions on Licence Order, section 104 ☐ Renovation of Municipal Home Order, section 135 ✕ Compliance Order, section 153 ☐ Work and Activity Order, section 154 ☐ Return of Funding Order, section 155 ☐ Mandatory Management Order, section 156 ☐ Revocation of License Order, section 157 ☐ Interim Manager Order, section 157
Intake Log # of original inspection (if applicable):	007822-18
Original Inspection #:	2018_730593_0004
Licensee:	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4
LTC Home:	Carlingview Manor 2330 Carling Avenue, OTTAWA, ON, K2B-7H1
Name of Administrator:	Matt Carroll

Background:

Ministry of Health and Long-Term Care (MOHLTC) Inspectors #593 and #655 conducted a Critical Incident Inspection at Carlingview Manor long-term care (LTC) home. As part of the inspection, two intake logs were inspected.
During the inspection, the inspectors determined that the Licensee, Revera Long Term Care Inc. (Carlingview Manor or the Licensee) failed to comply with section 5 of the Long-Term Care Homes Act, 2007 (LTCHA) and issued Compliance Order #001 (A1).
Pursuant to s. 153 (1)(a) of the LTCHA, Inspectors issued the following:

Compliance Order #001 (A1) relates to LTCHA, 2007 c.8, s. 5 and reads as follows:
Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. The Licensee shall prepare, submit and implement a plan for achieving compliance under s. 5 of the LTCHA. This plan shall include:

1. A written procedure, outlining the preventative maintenance (PM) requirement under s. 90 (1) (b) of O. Reg 79/10, for the windows and all window parts, including but not limited to: panels, sashes, frames, brackets, locks, screens and screws/bolts. Specific information must be documented in the procedure including but not limited to, information which ensures the following: all window panels are secured in the window frame, window panels cannot be removed from the window frames without tools, the windows cannot be opened to more than 15 centimeters, windows are in a good state of repair and reporting requirements related to safety concerns are met within the home. The procedure must also outline the documentation requirements for the preventative maintenance and auditing process.

2. A revision of the window cleaning procedure at the LTC home, including outlining the requirements for housekeeping staff to ensure window safety within the home when cleaning. This must include but is not limited to: the windows must not be removed without permission from the management of the home and during cleaning of the windows, housekeeping staff will ensure that the windows are in a good state of repair and any safety concerns related to window are to be immediately reported to the management of the LTC home.

3. An auditing schedule and to ensure audits are carried out and corrective actions, if required, are taken in a timely manner. This must include an appropriate auditing frequency. The audits are to be completed by the Environmental Services Manager (ESM) or appropriately trained designate. The ESM must ensure that any corrective actions are being implemented, that the window panels are secured in the window frame, the window panels cannot be removed from the window frames by any residents, especially those with exit seeking behaviours.

4. Education session, the content of which must include, but is not limited to:

i) A written procedure (as per point one), outlining the preventative maintenance requirement under s. 90 (1) b. of O. Reg 79/10, for the windows and all window parts.
ii) A revision of the window cleaning procedure at the LTC home, including outlining the requirements for housekeeping staff to ensure window safety within the home when cleaning (as per point two).
iii) The auditing scheduled and requirements (as per point three).
iv) PM's as per above items one, two and three for maintenance staff and item two for housekeeping staff, and the responsibilities of maintenance and housekeeping staff specifically related to window safety within the home.

This education training session is mandatory for all maintenance and housekeeping staff. The education must be provided by an appropriately trained individual(s). The Licensee must also develop a schedule for when the education training sessions(s) will be delivered.

5. A monitoring process, to ensure that where a resident demonstrating exit-seeking behaviours requires safety checks, those checks are provided at the frequency set out in the residents' plan of care; and,

6. A process through which the needs of residents' who demonstrate exit-seeking behaviours are assessed and reassessed on a regular basis, whenever there is a change in the resident's condition, and whenever the interventions in place were not effective, to ensure that they remain safe in the home.

This order must be complied by: November 30, 2018 (A1)
The above order is altered and substituted with the following Director Order.

Order #:	001

To **Revera Long Term Care Inc.**, you are hereby required to comply with the following order by the date set out below:

Pursuant To:

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:

Order:

The licensee shall prepare, submit and implement a plan for achieving compliance under s. 5 of the LTCHA. This plan shall include:
1. Written procedure(s), outlining the preventative maintenance (PM) requirement under s. 90(1) b. of O. Reg 79/10 for the windows and all window parts at the long-term care (LTC) home, including but not limited to panels, sashes, frames, brackets, locks, screens and screws/bolts. The written procedure(s) must include information which ensures the following: all windows that are large enough to allow residents to fall out must be secured sufficiently to prevent such falls; horizontal slider style window panels must be secured in the window frame; and window restrictors should only be able to be disengaged using a special tool or key. Windows cannot be opened to more than 15 centimeters, windows must be in a good state of repair and reporting requirements related to safety concerns are met within the home. The procedure must also outline the documentation requirements for the preventative maintenance and auditing process.
2. A revision of the window cleaning procedure at the LTC home, including outlining the requirements for housekeeping staff to ensure window safety within the LTC home when cleaning. This must include but is not limited to: windows must not be removed without permission from the management of the LTC home; supervision is provided by the LTC home during maintenance and cleaning of the windows to ensure the protection of the residents, the Licensee will ensure that adequate training and supervision is provided to ensure that housekeeping staff understand the risks, the precautions required, and the need to report any defects or concerns related to the windows to management and/or supervisor.
3. Ensuring that audits are conducted based on an appropriate auditing frequency schedule and corrective actions, if required, are taken in a timely manner. The audits are to be completed by the Environmental Services Manager (ESM) or appropriately trained designate. The ESM must ensure that any corrective actions are being implemented, that the window panels are secured in the window frame, and that the window panels cannot be removed from the window frames by any residents, especially those with exit seeking behaviours.
4. Education session, the content of which must include, but is not limited to:
i) A written procedure (as per point one), outlining the preventative maintenance requirement under s. 90(1)(b) of O. Reg 79/10, for the windows and all window parts.
ii) A revision of the window cleaning procedure at the LTC home, including outlining the requirements for housekeeping staff to understand the risks, the precautions required, and the need to report any defects or concerns related to the window safety within the home when cleaning to management and/or supervisor. (as per point two).
iii) The auditing schedule and requirements (as per point three).
iv) PM's as per above items one, two and three for maintenance staff and item two for housekeeping staff, and the responsibilities of maintenance and housekeeping staff specifically related to window safety within the home.
This education training session is mandatory for all maintenance and housekeeping staff. The education must be provided by an appropriately trained individual/s. The Licensee must also develop a schedule for when the education training sessions(s) will be delivered.

5. A monitoring process, to ensure that where a resident demonstrating exit-seeking behaviours requires safety checks, those checks are provided and done with enough frequency to ensure the residents safety and that the checks and frequency are set out in the residents' plan of care; and

6. A process through which the needs of residents' who demonstrate exit-seeking behaviours are assessed and reassessed on a regular basis, whenever there is a change in the resident's condition, and whenever the interventions in place were not effective, to ensure that they remain safe in the home.

This plan may be submitted in writing to Long-Term Care Homes Inspector at 347 Preston St, Suite 420, Ottawa, Ontario, K1S 3J4. Alternatively, the plan may be faxed to the inspector's attention at (613) 569-9670. This plan must be fully implemented by November 30, 2018.

Grounds:

1. The licensee has failed to ensure that the home was a safe and secure environment for resident #001.
A call was received from the long-term care home to the after-hours Action Line

to report an incident that resulted in the unexpected death of resident #001.
A critical incident report (CIS) was submitted by the LTC home to the Ministry of Health and Long-Term Care (MOHLTC), reporting that a deceased resident was found in the lower parking area by maintenance staff #109. After finding the resident, maintenance staff #109 reported the incident to the Executive Director (ED) #123 and the Assistant Executive Director (AED) #124. A code blue (medical emergency) was initiated at the LTC home and emergency services were called by staff member #121. The CIS documented that the resident's pulse was absent when discovered and that the police arrived within five minutes of the call and initiated an investigation. According to the CIS, PSW #102 found the window opened in resident #001's room and called the housekeeper to secure the windows which had been found on the floor. It was reported in the CIS that there was camera footage which showed resident #001 falling from the floor D window.
Resident #001 was elderly and had been a resident at the home for several years. During the resident's stay at the LTC home, the resident resided mostly on floor A. However, the resident was moved to floor B in 2017. Resident #001 was then moved to floor C, early 2018 and then to floor D several months later.
The LTC home has a security camera facing the parking area at the back of the home (rear entrance). The footage recorded the morning of resident #001's death was reviewed by Inspectors #593 and #655. It was observed that the resident fell from the window head first before hitting the ground.
The LTC home has a security camera in the west corridor of the building on floor D. The view was from above the elevators facing the west corridor and the entrance to resident #001's room could be seen. The footage recorded the morning of resident #001's death was viewed by Inspectors #593 and #655. Resident #001 was observed to enter their room. One minute and fifty seconds later, the resident was seen falling from a floor D window on the outside security camera. No staff or residents were observed to be near, entering or exiting their room during the time of the incident.
The following was observed at the LTC home, the day of resident #001's death by Inspectors #593 and #655:
1445 hours: The left side window located in resident #001's room which was the window resident #001 removed and subsequently fell from. Further observed was a larger upper window pane which did not open to the outdoors. Below the larger window, there was a horizontal slider style window. In the horizontal slider style window, two panels operated by sliding along a track in the window frame. The panels were held in place by the track and window frame. At the time of the observation, the placement of additional screws had been completed at the top of the window panel in the horizontal slider style window, preventing the panel on this window from being lifted up and away from the window track and frame. In between the two sliding windows, there was a screen. This was secured in place at the time of the observations.
1455 hours: The right-side window in another room, where Inspector #593 was able to remove one panel from the window track and frame. There was a screw in place along the track of the window, intended to prevent the window panel from sliding along the track to a point that would create an opening exceeding a specified dimension (10 centimeters or four inches). With those screws in place, Inspector #593 was able to lift the panel up without the use of significant force and away from the track and window frame, removing the panel entirely. During the inspection, all slider style windows within the home were bolted shut the same day of the incident by the LTC home. The window was observed before this had been completed.
Inspectors #593 and #655 reviewed resident #001's documented plan of care and found that the resident exhibited responsive behaviours including elopement, with a goal documented to have decreased episodes of exit seeking behaviour. Documented interventions included safety checks every hour, observations for exit seeking behaviours and a roam alert sensor applied in 2017.
A review of resident #001's progress notes by Inspectors #593 and #655, indicated a pattern of agitated and exit seeking behaviour in the nine days prior to their death, the following is a summary of the progress notes:

• Day 1, 14h06 - It was charted by PSW #118 that resident #001 was very agitated in the morning. Resident #001 had packed and taken some of their things to resident #002's room where they spent most of the shift.
• Day 2, 13h30 - It was charted by ADOC #115 that resident #001 was visiting with resident #002 in their room. They had developed a friendship. Resident #002 gave resident #001 their coat and resident #001 had been attempting to move items from their room into resident #002's room.
• Day 2, 13h56 - It was charted by RPN #116 that the Substitute Decision Maker (SDM) for resident #001 was called by staff and made aware of resident #001's behaviours. The SDM was notified that resident #001 would be moving to floor D.
• Day 2, 15h23 - It was charted by ADOC #115 that resident #001 was frustrated with the move to floor D. Resident #001 had been exhibiting responsive behaviours around the elevator. Huddles were held with staff on the floor to ensure high alert monitoring was in place.
• Day 2, 22h20 hours - Exit seeking noted by RPN #128.
• Day 4, 11h51 hours - Resident #001 said "I want to look for my friends", "can I go downstairs?" Resident #001 was asking to leave the unit to go down stairs to look for their friends. It was documented by RPN #107 that resident #001 required supervision from staff to ensure whereabouts, was at risk for exit seeking and staff were to continue to monitor resident #001's whereabouts.
• Day 5, 13h00 - It was charted by RPN #107 that resident #001 was arguing and stated, "I want to go look for my friend". Staff were trying to distract the resident, but they were trying to exit on the elevator to look for their friend and arguing with staff because they couldn't leave the unit. It was documented that resident #001 was at risk for elopement and staff were to continue to monitor their whereabouts and behaviour.
• Day 5, 15h06 - It was charted by RPN #107 that resident #001 was observed walking in the hallway stating, "I want to go to floor C to see resident #002". Resident #001 was returned to the unit by recreation staff and the charge nurse, resident #001 did not want to return to floor D. Resident #001 eventually came off the elevator and wanted to call their family member. Recreation staff dialed resident #001's family member and then resident #001 came off the telephone and was taken to their room by recreation staff and later, resident #001 was in the lounge talking about going to floor C. It was documented that resident #001 was at risk for elopement and staff were to continue to monitor resident #001's whereabouts.
• Day 5, 15h49 - Resident #001 was saying "I want to see resident #002." Resident #001 was agitated because they had been separated from their "friend". It was explained to the resident by staff member #129 that they did not have a key to the elevator, and resident #001 became even more agitated.
• Day 5, 22h32 - It was charted by RPN #130 that a co-resident pulled the fire alarm at 1815 hours, the stairs on zone A were opened and resident #001 ambulated to the door to exit. Two staff members and two PSW students stopped the resident immediately. The charge RN came to the unit immediately and the on-call physician was contacted. Resident #001 was given a particular medication at 1605 hours. At 1900 hours, the physician called the home and several orders were received. Resident #001's SDM was called to obtain consent for the administration of the newly prescribed drug regimen. Resident #001 was administered all medications, including PRN and scheduled HS medications. Resident #001 became calm, went to their room to rest. The particular medication PRN was given at 19h06 as per STAT order, with minimal effect. Another PRN of the same medication was given at 20h12 with good effect.
• Day 5, 23h10 - The charge RN #127 responded to a call on the unit approximately 1830 hours and upon arrival, the RPN on the unit reported that resident #001 had tried to exit the zone A exit door on the unit while the fire alarm was going off. Resident #001 stated that they were going to floor C to be with their friend and staff had intervened to prevent the resident going into the stairwell. Resident #001 was alert but very agitated on the unit, talking out loud and verbalizing their desire to go to floor C. The RN discussed with the RPN about resident #001's status and advised to contact the physician on call for

medications, as needed. Resident #001 settled in bed as the medication given as per the order was effective.
• Day 6, 21h48 - Exit seeking noted by RPN #128. Resident #001 continued to ask to go to floor C to see their friend. Redirected with little effect. It was documented that the staff would continue to monitor.
• Day 7, 14h37 - It was charted by RPN #131 that resident #001 was exit seeking this shift in the morning, inquiring how to get to floor C to meet with their friend. Resident #001 was easily redirected.
• Day 7, 21h45 - Behaviour monitoring continued. Exit seeking noted at times by RPN #128 on this shift. Resident #001 was found in resident #002's room on floor C around 1640 hours and was guided back to floor D. Resident #001 was given a specific medication as a PRN. Resident #001 was under close monitoring since then. It was documented by RPN #128 that the staff would continue to monitor their behavior.
• Day 8, 06h28 hours- Behaviour monitoring was initiated every shift for seven days which included monitoring and documenting responsive behaviours. It was documented by RN #132 to ensure that PSW's were completing the behaviour mapping charting.
A review of resident #001's plan of care by Inspector #593 and #655 for the same month of resident #001's death, found the following orders and medication administration records (MAR):
• Behaviour monitoring every shift for one week. Every shift for seven days until finished. Monitor and document responsive behaviours. Ensure PSW's complete behaviour mapping charting. Start date: Day 1 at 1500 hours.
o This was charted as completed starting day 1 evening shift (1500 - 2300 hours) until day 7 day shift (0700 - 1500 hours).
• Monitor resident hourly for seven days for exit seeking. Every shift for safety. Start date: Day 1, discontinued date: Day 4 at 1121 hours.
o This was charted as completed starting day 1 night shift (2300 - 0700 hours) until day 4 day shift (0700 - 1500 hours).
• Resident safety review (Nurse). Elopement risk, behaviours. Discontinued date: Day 9 at 2300 hours.
o This was charted as completed from day 1 day shift (0700 - 1500 hours) until day 9 evening shift (1500 - 2300 hours).
• Monitor resident hourly for seven days for exit seeking. Every hour for safety for seven days until finished. Start date: Day 1 at 1200 hours.
o This was charted as completed hourly starting day 2 at 2400 hours until day 8 at 0700 hours.
The following directions and task completion documentation were found in the point of care (POC) system:
• Resident safety monitoring. Elopement risk. Monitor whereabouts every hour. This was charted as completed for the following times:
Day 1, 2018 0030 hours – Day 4, 2018 0330 hours
Day 4, 2018 0730 hours – Day 13, 2018 1430 hours
Day 14, 2018 0730 hours – Day 14, 2018 2200 hours
Day 14, 2018 0730 hours – Day 17, 2018 0730 hours

During an interview with Inspectors #593 and #655 on April 19, 2018 at 1132 hours, PSW #100 who regularly worked on floor D and was working on floor D at the time of resident #001's death, reported that resident #001 had exit seeking behaviours related to wanting to see their friend on floor C. PSW #100 added that resident #001 was probably exit seeking the morning of their death, as the resident was walking continuously throughout the unit. PSW #100 confirmed that the resident was on hourly safety checks but the last time they saw the resident was during shift report, which was just after 0700 hours.
During an interview with Inspectors #593 and #655 on April 19, 2018 at 1230 hours, PSW #101 who regularly worked on floor D and was working on floor D at the time of resident #001's death, reported that resident #001's behaviour was mostly related to wanting to be out of the unit.
During an interview with Inspectors #593 and #655 on April 19, 2018 at 1330 hours, PSW #102, the PSW assigned to resident #001 the day of their death, reported that resident #001 wanted to leave the unit. Resident #001 had only

been on floor D a couple of weeks, and mostly wanted to leave the unit. Resident #001's focus was that they wanted to leave, to go home, as they were on floor C previously. PSW #102 further reported that at 0800 hours, the day of resident #001's death, they entered resident #001's room and found it really cold. The PSW found the window panels down, both interior and exterior windows as well as the screen. PSW #102 told the housekeeper and the housekeeper called for maintenance to fix the window. PSW #102 went to provide care for another resident in the same room until 0830 hours and reported that they did not see resident #001 during this time and by 0830 hours, the window had been fixed. PSW #102 reported that the resident was on hourly safety and monitoring checks which started at 0730 hours on the day shift. PSW #102 reported that they completed the safety check at 0730 hours, but did not complete the check at 0830 hours as they did not see the resident. PSW #102 said that if they did not see resident #001, they are supposed to actively look for the resident. However as 0830 hours is breakfast time, the resident would usually be in the dining room and the PSW was providing care for other residents at this time.

During an interview with Inspectors #593 and #655 on April 20, 2018 at 0940 hours, PSW #105, who was working on floor D, the day of resident #001's death and reported that resident #001 set off the fire alarm last week and was able to reach floor C to see resident #002. PSW #105 reported that they were not aware of any safety and monitoring checks for resident #001.

During an interview with Inspectors #593 and #655 on April 20, 2018 at 1020 hours, PSW #106, who was working on floor D the day of resident #001's death, reported that resident #001 just wanted to go, mostly to floor C to see their friend and that they had attempted to exit the unit many times previously via the elevator. PSW #106 further reported that resident #001 was on safety and monitoring checks and it was the responsibility of all staff to watch the resident so that they did not leave the unit.

During an interview with Inspectors #593 and #655 on May 01, 2018 at 1039 hours, PSW #111, who worked regularly on floor C reported that when resident #001 was on floor C, the resident would say “I want to escape, it’s like I am in jail” however they did not know of the resident actually trying to leave floor C.

During an interview with Inspectors #593 and #655 on May 02, 2018 at 0708 hours, PSW #114, who worked the night shift on floor D finishing at 0700 hours the day of resident #001's death, reported that they provided care for resident #001 during this shift, however they were not aware of any safety and monitoring checks for this resident.

During an interview with Inspectors #593 and #655 on April 20, 2018 at 1100 hours, RPN #107, who was the regular dayshift RPN on floor D, reported that resident #001 had behaviours related to wandering and wanting to leave the unit. Resident #001 had attempted to leave the unit previously via the elevator and if staff tried to stop the resident, they became angry. RPN #107 further indicated that the resident exited the unit several days earlier, and they were not sure how they exited, but the resident was returned safely to floor D. RPN #107 confirmed that resident #001 was on safety and monitoring checks for exit seeking.

During an interview with Inspectors #593 and #655 on May 01, 2018 at 1200 hours, RN #113, who was the regular dayshift RN on floors C and D, reported that resident #001 had exit seeking behaviours including asking for the elevator key, trying to leave on the elevators with staff or visitors and talking about going to floor C to visit resident #002. The behaviours had been present for quite awhile but had worsened recently when the resident was moved to floor C, and again after the move to floor D. Resident #001 had a wander guard bracelet for this reason and was also on safety monitoring after the move to floor D. RN #113 indicated that resident #001 had a successful exit once that they knew of, where resident #001 made it to floor C.

During an interview with Inspectors #593 and #655 on May 9, 2018 at 1046 hours, Maintenance staff #119 reported that they fixed the window in resident #001’s room before there was knowledge of the incident occurring. Staff member #119 further reported that both interior and exterior windows were out of the window frames and the screen was bent. They added that the windows

were removed by housekeeping for cleaning especially on floors C and D as they received more of the lint blown up from the laundry exhaust fan as they were the levels of the home that were closer to the laundry.
During an interview with Inspectors #593 and #655 on May 22, 2018 at 1033 hours, Maintenance staff #125 reported that they were the person that looked after the preventative maintenance (PM) in the home and had been in that role for at least two years. Maintenance staff #125 further reported that they were aware that housekeeping staff previously removed windows for cleaning, as after some of the windows were removed from the frames, they needed maintenance staff to get them back in the window frame. They added that the window track was supposed to be pressed down by some rubbers but they were gone, so the track could be crooked and the housekeeping staff did not know how to push it back. They confirmed that the housekeeping staff did not need any tools to remove the windows from the tracks. Maintenance staff member #125 reported that there used to be PM on the windows which was completed when the room was vacated and in preparation for a new resident. There was a check sheet that they completed which included checking that the windows did not open more than 10 centimetres or four inches and that the screens were intact, but they do not have that anymore and it has been at least two years since they had used this check sheet.
During an interview with Inspectors #593 and #655 on April 20, 2018 at 1257 hours, housekeeping staff #110 reported that they were the regular housekeeper for floor D. The morning of resident #001's death, PSW #102 approached housekeeping staff #110 and told them that the window was open and to phone maintenance. When housekeeping staff #110 entered resident #001’s room, and observed that the windows were opened, they called the maintenance department. Maintenance staff #119 arrived within 5-10 minutes and secured the windows. Housekeeping staff #110 reported that resident #001 told them previously that they wanted to see their friend who was on floor C and that they had also seen the resident trying to get onto the elevators.
During a second interview with Inspectors #593 and #655 on May 22, 2018 at 0933 hours, housekeeping staff #110 reported that until recently, they would remove the inner windows from the tracks to clean them and they did not require any tools to remove the windows. Some of the windows were easy to remove however sometimes they needed to call maintenance to help put them back in the window frames. Housekeeping staff #110 added that the windows on floors C and D would get more of a buildup of dust due to being closer to the dryer vents from the laundry. The windows would usually be cleaned during the deep cleans and sometimes residents would still be in the room when these cleans were taking place. The outer surface of the exterior window panel was cleaned twice a year by a contractor; whereas the interior window panel was being removed from the window frame more often, as needed, when they were observed to be unclean, by housekeeping.
During an interview with Inspectors #593 and #655 on May 14, 2018 at 1044 hours, Housekeeping staff #122, who was the regular housekeeper for floor C reported that until recently when the windows were bolted shut, they would remove windows out of the window frames to clean them completely, at least once per year. They would remove both the interior and exterior windows, wash each window and the window tracks. The housekeeping staff did not need any tools to remove the windows, however sometimes the tracks would jam and they needed to call maintenance to put the windows back in. The windows were old, they needed to be replaced, reported housekeeping staff #122 and when the windows were cleaned as part of the deep clean, they would try to ensure that the resident was not in the room but this was not always possible.
During an interview with Inspectors #593 and #655 on May 2, 2018 at 1000 hours, ADOC #115 reported that resident #001 was exit seeking on both floors C and D. ADOC #115 further reported that resident #001 was on safety and monitoring checks at the time of their death which was supposed to be hourly. They indicated that the LTC home were definitely keeping a close eye on the resident after their most recent move.
During an interview with Inspectors #593 and #655 on May 9, 2018 at 1302 hours, Environmental Services Manager (ESM) #120 reported that after the

incident resulting in resident #001's death, the Environmental Services department were directed by the licensee to secure the windows. They had an interim fix which involved bolting the windows shut however the permanent solution was to fix the moveable upper track as every window had a fixed lower track and a moveable upper track. The moveable upper track was there to facilitate or make it easier to remove the window for cleaning. They pushed the upper track down, added three screws to fix it in place, so that the window could not be pushed up and taken out of the window frame. The ESM further reported that there were checks on the windows from maintenance staff which included checking the windows and screens for cleanliness and checking to ensure the window did not open more than four inches. These checks were to happen quarterly however this was not documented as the preventative maintenance (PM) was received on maintenance staff's iPods, and when staff completed the check, the PM was closed online and no longer visible.
During an interview with Inspectors #593 and #655 on May 22, 2018 at 1051 hours, Executive Director (ED) #123 reported that resident #001 was on hourly safety checks and on the hour, the resident was to be observed. If the resident could not be located, a code yellow (missing resident) should be called. The ED added that there were quarterly preventative maintenance checks on the windows which involved checking that the limiter screw was in place and that the windows were not falling out of the frame and that they were in good repair. The ED confirmed that there was a policy in place related to the PM checks for windows.
A review of the home's policy from the environmental services manual "Maintenance Department, Subject: Windows" Index I.D. ES E-75-20 dated December 1, 2017, found that the ESM or designate was required to inspect the windows monthly. The policy further documented to check all windows to ensure that they had a screen that was in good repair and that the seals were in good condition with no leakage. The policy also required that all window locks and latches were in good repair and check all windows to ensure that they did not open more than 10 centimeters or four inches.
Resident #001 had a history of exit seeking behaviours which increased after the move to floor D. Shortly after the move to floor D, resident #001 was able to physically remove two window panels and one screen from the window frame of a floor D window and following this, resident #001 fell to their death. The licensee knew that windows at the LTC home were easily removed from the tracks when they were being cleaned by staff in the LTC home. In addition, staff at the LTC home were aware that resident #001 was exhibiting specific exit seeking behaviours which required the resident's frequent monitoring. As such, the licensee has failed to ensure that the home was a safe and secure environment for resident #001.
The following written notifications were also issued:
1. s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan (refer to written notification #2).
2. s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) care set out in the plan has not been effective (refer to written notification #2).
3. s. 8. (1) Where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system,
(b) is complied with (refer to written notification #3).
4. s.16. Every license of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres (refer to written notification #4).

The decision to issue this compliance order was based on the severity of the issue which was determined to be a level 4 as there was immediate jeopardy/risk resulting in death. Although the scope of the issue was isolated; the issue has the potential to affect all residents in the home and the Licensee

has a history of previous non-compliance under s. 5 of the LTCHA that included:
WN issued on May 6, 2016 (2016_380593_0012)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :
November 30, 2018

This order must be complied with by:	November 30, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Long-Term Care Inspections Branch
1075 Bay St., 11th Floor, Suite 1100
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.

Issued on this 13th day of November, 2018	
Signature of Director:	
Name of Director:	Lynne Haves