Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 11, 2016	2016_346133_0029	019323-16, 016633-16	Critical Incident System

Licensee/Titulaire de permis

GENESIS GARDENS INC
438 PRESLAND ROAD OTTAWA ON K1K 2B5

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

FOYER ST-VIATEUR NURSING HOME
1003 Limoges Road South Limoges ON K0A 2M0

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

JESSICA LAPENSEE (133)

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): July 20th and 21st, 2016

This Critical Incident inspection is related to three critical incident reports that the home submitted related to unplanned evacuations.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, and two residents.

The Inspector reviewed the information contained within three Critical Incident Reports. The Inspector reviewed the emergency plans in place at the time of the inspection that provide for dealing with fires and for dealing with evacuation of the home. The Inspector reviewed the home's revised emergency plan that provides for dealing with fires, which was in draft form, otherwise known as the Fire Safety Plan.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

s. 107. (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 79/10, s. 107 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10 (1) 1 in that the licensee failed to ensure that the Director was immediately informed of an unplanned evacuation.

As per a Critical Incident Report (CIR), there was an unplanned evacuation at the home on Saturday, June 25th, 2016. All residents on B wing were moved to the main lounge, in response to a fire alarm set off by heat sensors in the attic. The fire department responded and allowed the residents to return to B wing without incident. The CIR was submitted through the Critical Incident System, by the Administrator, on Monday, June 27th, 2016.

On July 21, 2016, the Administrator acknowledged to the Inspector that the unplanned evacuation had not been reported immediately. [s. 107. (1)]

2. The licensee has failed to comply with O. Reg. 79/10, s. 107 (2) in that the licensee failed to ensure that two unplanned evacuations, that occurred outside of normal business hours, were reported using the Ministry's method for after-hours emergency contact.

As per O. Reg. 79/10, s. 107 (1) 1, the licensee must report unplanned evacuations immediately.

Unplanned evacuations and all other critical incidents that require an immediate report, that occur after hours, must be reported by phoning the after-hours pager number. The process went into effect in 2007. Most recently, on February 12, 2015, a memo was issued to all Long Term Care Home Licensees and Administrators which reviewed reporting requirements for mandatory and critical incidents, including use of the after-hours pager.

As per a Critical Incident Report, there was an unplanned evacuation at the home on Saturday, May 28th, 2016. All residents were moved to the outdoors, in response to a fire alarm set off by heat sensors in the attics. The fire department responded and cleared the building for re-occupancy without incident. The evacuation was reported immediately in that the Administrator submitted a Critical Incident Report on the day of the evacuation through the Critical Incident System (CIS), however, the evacuation was not reported through the after-hours pager. The CIS is not monitored outside of normal business hours.

As per a Critical Incident Report, there was an unplanned evacuation at the home on Saturday, June 18th, 2016. All residents were moved to the main lounge, in response to a fire alarm set off by heat sensors in the attics. The fire department responded and allowed the residents to return to the care units without incident. The evacuation was reported immediately in that the Administrator submitted a Critical Incident Report on the day of the evacuation through the Critical Incident System (CIS), however, the evacuation was not reported through the after-hours pager. The CIS is not monitored outside of normal business hours.

On July 21, 2016, the Administrator indicated to the Inspector that he had not been aware of the Ministry's method for after-hours emergency contact. [s. 107. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with the requirement that where the Director is to be immediately informed of a critical incident, the report is made immediately and, if the incident occurs after normal business hours, the report is made using the Ministry's method for after hours emergency contact, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (6) The licensee shall ensure that the emergency plans for the home are evaluated and updated at least annually, including the updating of all emergency contact information. O. Reg. 79/10, s. 230 (6).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 230 (6) in that the licensee has failed to ensure that the emergency plans are evaluated and updated at least annually, including the updating of all emergency contact information.

As per Critical Incident Reports submitted to the MOHLTC, there were unplanned evacuations at the home on May 28th, June 18th and June 25th, 2016. The evacuation in May was a full evacuation, to the outside of the home, and the evacuations in June were partial evacuations, to the main lounge. The evacuations were a result of fire alarms, set off by heat detectors in the attic. There was no fire involved, on any of the occasions.

On July 20th, 2016, the Inspector requested that the Administrator provide the home's emergency plan that provides for dealing with fires and with evacuation of the home. The Administrator advised that the emergency plan that provides for dealing with fires was currently under revision, in collaboration with the local fire department. On July 21st, 2016, the Administrator informed that the final draft had been provided to the Fire Chief, via email.

The emergency plan in place at the time of the inspection, for dealing with fires and for dealing with evacuation of the home, as provided by the Administrator, were last reviewed by the Director of Care in 2013. The Director of Care explained to the inspector that it was not her role to update the plans, and she did not review them annually. The Administrator informed that he started in the position in 2013, and that there had been no process in place to ensure that the emergency plans were evaluated and updated at least annually. He explained that he was now aware of the requirement, and that he had chosen to start with the emergency plan that provides for dealing with fires.

It was noted that emergency contact information for residents and staff was up to date at the time of the inspection [s. 230. (6)]

Issued on this 11th day of August, 2016

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

Original report signed by the inspector.