Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 7, 2014	2014_189120_0049	H-000959-14	Complaint

Licensee/Titulaire de permis

DALLOV HOLDINGS LIMITED
441 MAPLE AVENUE, BURLINGTON, ON, L7S-1L8

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

MAPLE VILLA LONG TERM CARE CENTRE
441 MAPLE AVENUE, BURLINGTON, ON, L7S-1L8

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 25, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, registered staff, personal support workers and maintenance staff.

During the course of the inspection, the inspector(s) toured the home, took illumination measurements, tested stairwell and perimeter door security and reviewed the home's missing persons policy and procedures.

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

Findings of Non-Compliance were found during this inspection.

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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1) The licensee did not ensure that a door leading to an exterior and unsafe portion of the home was kept locked on a specified date in 2014. A resident exited the building without staff knowledge and was seen by a member of the public almost immediately who reported the incident to the home staff. A registered nurse escorted the resident back down into the home without injury.

During the inspection on July 25 2014, the maintenance person confirmed that a specified door to the exterior of the home was equipped with a lock on the date of the incident. After the administrator completed her investigation into the incident, it was suspected that a contractor who was using the exterior portion of the home three days prior left the door unsecured when they left. No process was in place at the time to check the specific door, however registered staff had the duty to check and document the status of other doors. Since the incident, the security of the specified door has been added to the nursing routine. In addition, during the inspection, verification was made that the door was equipped with a different type of lock identified as a "store room lock" which locked automatically once the key was removed. The previous lock required someone to push a button on the opposite side of the door knob to lock it.

2) The licensee did not ensure that all doors were connected to an audio visual enunciator that was connected to the nurses' station nearest to the door.

2.1 The side entrance door closest to the nurse's station on the main floor did not trigger the visual or audio enunciator on the panel at the nurse's station. The door was tested 3 times and held open for more than 3 minutes each time. A registered staff member was stationed at the panel while the door was held open to confirm that the light or sound did not trigger.

2.2 The entrance to the three stairwell doors from the 2nd floor were not connected to an audio visual enunciator that was connected to the nurses' station nearest to the doors. The audio and visual enunciator for the 2nd floor stairwell doors were connected to the main floor nurses' station and not the 2nd floor nurses' station. [s. 9(1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that doors leading to the outside of the home are kept locked and that doors to stairwells and to the outside of the home are connected to the resident-staff communication and response system, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

The lighting requirements were not maintained as set out in the lighting table. The home was built prior to 2009 and was therefore required to provide lighting levels identified in the Table under "All Other Homes".

A portable hand held light illumination meter was used to take measurements of the main floor activity room, short corridor and long corridor. Other areas of the home were not evaluated. The meter was held parallel to the floor and 30 inches above the floor when measurements were taken.

The activity room was equipped with 8 flush mounted light fixtures with opaque glass. Not all of the fixtures contained two compact fluorescent bulbs, which may have affected illumination levels. The general illumination level was 100 lux when standing directly under the lights and 50 lux between the light fixtures. Some natural light entered the room through several windows. The minimum required lux level of 215.28 was not achieved.

The short corridor was equipped with recessed fluorescent tube lighting covered by an opaque shield lense or cover. The illumination levels were adequate directly under the fixtures, however, the fixtures were spaced 8 feet apart. The illumination levels between the fixtures dropped dramatically to 50 lux. The required minimum of 215.28 lux continuous lighting was not achieved.

The long corridor was equipped with flush mounted fluorescent tube lighting spaced 10 feet apart. The illumination levels under the fixtures was adequate, however the level between the fixtures was 20 lux. The required minimum of 215.28 lux continuous lighting was not achieved.

According to the Administrator, the facility was assessed for illumination several years prior and was found to be in conformance with the lighting table. Discussion was held regarding a new assessment based on findings above to determine if all areas of the home are in compliance with the lighting table.
[s. 18]

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 to ensure that the lighting requirements are maintained as set out in the Table, to be implemented voluntarily.

WN #3: 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 :

The licensee did not ensure that all windows in the home that opened to the outdoors were restricted to a an opening of 15 centimetres. Several windows in the main floor dining room and a window in the short corridor on the main floor were observed to be missing restrictors. Several of these windows were tested and slid open more than 30 centimeters. The administrator explained that the windows were recently cleaned by a window company who may have failed to replace the restrictors. However, no one in the home verified that the windows were restricted to 15 centimeters after they were cleaned. [s. 16]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

The resident-staff communication and response system (RSCRS), which used sound to alert staff, was not calibrated so that the level of sound was audible to all staff. Calibration of the system refers to the process of ensuring that the sound is not overly loud in one location to disrupt residents and staff and not overly quiet so that staff are not able to hear it when working in resident rooms.

The audible portion of the RSCRS was located to be emanating from two points on the 2nd floor, from the enunciator panel at the nurse's desk and from a panel located on the long corridor wall in a niche near the dining room. A discussion was held with several staff members about the level of audibility both at the nurses' station and elsewhere in the building. Staff agreed that in general, the sound at the nurses' station was disruptive and interfered with their ability to use the phone and the sound being inadequate when competing sounds were being made, especially when staff were working in resident washrooms. The sound quality was confirmed to be poor when in rooms near the half way point down the corridor. The level of audibility was similar on the main floor at the nurses' station and it was noted that an additional speaker had been added to the corridor to increase audibility. [s. 17(1)(g)]

Issued on this 7th day of August, 2014

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