Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
September 21, 2011	2011-072120-0018	H-001301-11 Critical Incident

Licensee/Titulaire

Maryban Holdings Ltd., 3700 Billings Court, Burlington, ON L7N 3N6

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

Oakwood Park Lodge, 6747 Oakwood Drive, Niagara Falls, ON L2E 6S5

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

Bernadette Susnik - Environmental Health #120

Inspection Summary/Sommaire d'inspection

The purpose of this visit was to conduct a critical incident inspection.

During the course of the inspection, the inspector spoke with the Administrator and Director of Care.

During the course of the inspection, the inspector conducted a walk-through of the entire home and tested the door access control systems and the resident-staff communication response system.

The following Inspection Protocol was used during this inspection:

- ***Safe and Secure Home***

There are findings of Non-Compliance as a result of this inspection. The following action was taken:

4 WN
1 VPC
1 CO - #001

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: ***The licensee has failed to comply with O. Reg. 79/10, s.*** **9.1.i.,ii., and 4.** *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*

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*

Findings:

Two sliding patio glass doors were found to be wide open during the inspection on September 21, 2011 between 10:30 and 11:30 a.m. The doors are located in the south-west dining room and south-west lounge areas. The area outside of these doors is not enclosed and the doors are therefore considered perimeter doors that lead "outside" of the home. The doors are not equipped with secure locks or alarms.

Six perimeter doors which were found to be unlocked in the home and which lead to unenclosed outdoor areas, were noted to be equipped with an alarm only which is not considered a door access control system.

The home currently is not equipped with a generator to supply back up power to the resident-staff communication and response system and the door access control systems which currently are equipped with magnetic locks. The emergency plan requires amending to include staffing patterns to secure each door.

Additional Required Actions:

CO - #001 – Refer to the "Order of the Inspector" form for further details.

WN #2: ***The licensee has failed to comply with O. Reg. 79/10, s. 17.(1)(g).*** *Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,*

(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.

The resident-staff communication and response system currently available in the home is calibrated so that staff can hear the sound in the halls etc. However, the system does not produce the same level of audibility for the doors which have been tied into the panel. The panel can barely be heard more than a few meters from the nurse's desk where the panel is located. If staff are not in the vicinity of the door which has alarmed, staff are not going to hear the alarm. The sound that does emit from the doors is very loud and quite disturbing to occupants and should therefore be calibrated so that it sounds equally throughout the home area which is covered by that nurse's station. Therefore when exit doors are breached in the north, east and west wings, the sound must be heard equally throughout those 3 wings and the nurse's station that covers those wings.

Additional Required Actions:

CO - #001 - Refer to the "Order of the Inspector" form for further details.

WN #3: The licensee failed to comply with O. Reg. 79/10, s. 305(3)1. *A licensee may not commence any of the following work without first receiving the approval of the Director.*

1. Alterations, additions or renovations to the home.

A sprinkler system was installed in the home within the last 3 months and the home did not receive the approval of the Director for this work. The home initiated the installation of door access control systems on September 21, 2011 without the approval of the Director. Both types of installations are considered alterations to the home.

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 in respect to ensuring that the home receives approval from the Director before any alterations, additions or renovations are commenced in the home.

WN #4: ***The licensee failed to comply with O. Reg. 79/10, s. 107(4)4.i & ii.*** *A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:*

4. Analysis and follow-up action, including,

i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.

Findings:

A critical incident was submitted to the Ministry of Health and Long Term Care in 2011 for the elopement of an identified resident. In the report submitted by the home the section titled "**IV Analysis and Follow-up**" is not complete. Under "what immediate action was taken to prevent recurrence", the Director of Care identifies a decision regarding the resident's accommodations. The information provided does not include an analysis for the risk of elopement. In this particular case, no analysis was conducted. Other residents at risk of leaving were not considered in the analysis to preventing recurrence. No consideration was given to the potential for other residents to elope undetected, by punching a code, as in this situation. Methods to prevent recurrence have not been established.

Regarding long term actions to prevent recurrence, the Director of Care indicated that "residents who are elopement risks are liable to exit without staff being immediately aware, so we do not admit residents who are known to be elopement risks". This response does not identify long term actions to prevent recurrence. All residents have the potential to wander and leave the building, however no consideration was given to improving the perimeter door security, changing policies on posting door codes and assessing all residents routinely for elopement risk. The long-term action of "not accepting residents known to be an elopement risk" is not a long-term solution.

Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.

B. Smith

Date of Report: (if different from date(s) of inspection).

Oct. 12/11

Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

	☐ Licensee Copy/Copie du Titulaire	☒ Public Copy/Copie Public	
Name of Inspector:	Bernadette Susnik	**Inspector ID #**	120
Log #:	H-001301-11		
Inspection Report #:	2011-072120-0018		
Type of Inspection:	Critical Incident		
Date of Inspection:	September 21, 2011		
Licensee:	Maryban Holdings Ltd., 3700 Billings Court, Burlington, ON L7N 3N6		
LTC Home:	Oakwood Park Lodge, 6747 Oakwood Drive, Niagara Falls, ON L2E 6S5		
Name of Administrator:	Paul Taylor		

To ***Maryban Holdings Ltd.***, you are hereby required to comply with the following order by the dates set out below:

Order #	001	**Order Type**	Compliance Order, Section 153 (1)(a) and (b)

Pursuant to: Ontario Regulation 79/10, s. 9.1.i.,ii., and 4. 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

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.

Pursuant to: Ontario Regulation 79/10, s. 17(1)(g). Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,

(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.

Order:

The licensee shall:

1 Secure immediately the sliding patio glass doors located in the south west dining room and south west lounge so that the doors are kept closed and secured to prevent undetected resident egress.

2 Prepare and submit a plan to the Inspector by October 14, 2011 which identifies and addresses how all of the perimeter doors leading to unenclosed outdoor areas will be kept closed and secured to prevent undetected resident egress. Provide timelines by when the above noted sections will be in compliance. The plan shall then be implemented upon Ministry of Health approval.

3 Prepare, submit and implement a plan to the Inspector by October 14, 2011 which identifies and addresses the safety risks posed by the unlocked doors, which also includes the emergency contingency plans to secure points of egress should the power supply fail.

All plans and documents to be submitted by mail to Bernadette Susnik, LTC Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 119 King St. West, 11th floor, Hamilton, ON L8P 4Y7 **or** by e-mail to Bernadette.Susnik@ontario.ca.

Grounds:

Two sliding patio glass doors were found to be wide open during the inspection on September 21, 2011 between 10:30 and 11:30 a.m. The doors are located in the south-west dining room and south-west lounge areas. The area outside of these doors is not enclosed and the doors are therefore considered perimeter doors that lead "outside" of the home. The doors are not equipped with secure locks or alarms.

Six perimeter doors which were found to be unlocked in the home and which lead to unenclosed outdoor areas, were noted to be equipped with an alarm only which is not considered a door access control system.

The home currently is not equipped with a generator to supply back up power to the resident-staff communication and response system and the door access control systems which currently are equipped with magnetic locks. The emergency plan requires amending to include staffing patterns to secure each door.

The resident-staff communication and response system currently available in the home is calibrated so that staff can hear the sound in the halls etc. However, the system does not produce the same level of audibility for the doors which have been tied into the panel. The panel can barely be heard more than a few meters from the nurse's desk where the panel is located. If staff are not in the vicinity of the door which has alarmed, staff are not going to hear the alarm. The sound that does emit from the doors is very loud and quite disturbing to occupants and should therefore be calibrated so that it sounds equally throughout the home area which is covered by that nurse's station. Therefore when exit doors are breached in the north, east and west wings, the sound must be heard equally throughout those 3 wings and the nurse's station that covers those wings.

The Order must be complied with by:	Immediately and October 14, 2011

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 service for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:.

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
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 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 group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

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

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2 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 23rd day of September, 2011.	
Signature of Inspector:	B. Susnik
Name of Inspector:	Bernadette Susnik
Service Area Office:	Hamilton