Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 21, 2021	2021_831211_0014	009290-21	Critical Incident System

Licensee/Titulaire de permis

United Counties of Prescott and Russell
59 Court Street Box 304 L'orignal ON K0B 1K0

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

Residence Prescott et Russell
1020 Cartier Boulevard Hawkesbury ON K6A 1W7

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

JOELLE TAILLEFER (211)

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): September 1, 2, 3, 13, 14, 15, 16, 20, 21, 22, 24, 2021 (onsite), September 27, 28, 2021 and October 6, 13, 14, 2021 (offsite).

The following intake was inspected:
Log # 009290-21: a critical incident report related to a fall incident that causes an injury for which the resident was taken to the hospital and resulted in a significant change in resident's health status.

It is noted that inspector Pamela Finnikin # 720492 participated in this inspection as an observer on August 30, 31, 2021 and September 1, 2, 3, 2021.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Assistant Director of Care (ADOC), Food Service Supervisor/Recreation and Programs Manager, Environmental Services Manager, Clinical Care Coordinator, Administrative Services Supervisor, several Registered Nurses (RNs), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), Physiotherapist Assistant (PTA), housekeeping Aide, the Schedule Technician, Archive Clerk, Food Service Workers, Laundry aides, Maintenance staff, Purchasing and Inventory Clerk and residents.

In addition, the inspectors reviewed several residents' health care records, reviewed "blueRover" program documentation and "UCPR Prescott & Russell" temperature sheets and the "Verification de la temperature" sheets, correspondence, staffing schedules, Policies and procedures: #650.01 "Bâtiment-Procédure générale" related to "Ascenseur" dated June 2016, #635.03 "Entretien du Bâtiment-Climatisation et Ventilation" related to "Changement des filtreurs de la ventilation centrale et autre" dated November 2016, #635.02 "Entretien du Bâtiment-Climatisation et Ventilation" related to "Installation d'un climatisateur-chambre d'un resident" dated February 2018, #635.01 "Entretient du Bâtiment-Climatisation et ventilation" related to "Aire de refroidissement/prise de température» dated June 2018, #760.20 "Administration/Santé et Sécurité" related to "Maladies liées à la chaleur" dated August 2018, #760.07" Administration" related to "Maladies liées à la chaleur" dated March 2014, #330.09 "Services des soins infirmiers" related to "Moyen de contention aux residents/P.A.S.D. (Positionning Assistant Service Device)" dated Dated December 2017. The inspector observed resident care and services related to Infection Prevention and Control procedures and techniques.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Safe and Secure Home

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

- **5 WN(s)**
- **3 VPC(s)**
- **2 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	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 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; O. Reg. 363/11, s. 1 (1, 2).

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
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).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents do not have access to all non-residential areas.

Every licensee of a long-term care home shall ensure that the following rules are complied with where all doors leading to non-residential areas 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.

Inspector #211 observed that the home has two side by side elevators. These two elevators are accessible from the third floor to the basement level. Both elevators are equipped with a keypad to restrict resident access to the basement. A code needs to be activated on the keypad to send the elevator to the basement. The basement level was identified as a non-residential area of the home. It is noted that, when the elevators are signaled from the basement to go to the basement level, any person who is in the elevator at the time of the signaling, will be brought to the basement and have access to the non-residential areas in the basement.

Inspector #211 reviewed the home's policy #650.91 titled "Ascenseur" dated June 2016 that was placed on the wall between both elevators in the basement. The Policy's documentation written in French indicated "When a staff member pressed the button to request the elevator to the basement, the staff must wait for the arrival of the elevator to ensure that a resident, unwittingly, was brought down to the basement".

A resident's progress notes written on a day in 2021, indicated that the resident was brought down to the basement, then climbed up the stairs from the basement to the first floor. The resident was found by a staff member on the first floor.

On September 16, 2021, Inspector #211 observed that the home's basement is deemed to be a non-residential area. The inspector noted that at the end of a hallway there was an unlocked door leading to a stairwell leading to the first floor that was not equipped with a door access control system nor equipped with an audible door alarm. On September 22, 2021, the door leading to the stairwell was still closed but unlocked.

Interview with a staff member stated that twice this year two unidentified residents were inadvertently brought down to the basement by the elevator. Moreover, a similar incident occurred approximately six months ago.

The DOC stated that the resident's incident occurred because while the resident was in the elevator, a staff member signaled the elevator from the basement. The unknown employee left the area instead of waiting for the elevator doors to open. The resident climbed the stairs from the basement to the first floor until the resident was found by an employee. The DOC stated that the resident was able to use a mobility device independently and take the elevator.

The Environmental Services Manager acknowledged that the door does not have a locking mechanism and that it should be kept closed and locked, equipped with a door access control system that is always kept on and equipped with an audible door alarm as it leads to a stairwell.

As such, there was a potential safety risk for the resident as the resident was able to access non-residential areas of the home.

Sources: Review of a resident's health care records and the home's policy #650.91 titled "Ascenseur" dated June 2016. Inspector #211 observation of the home's basement and the basement's doors. Interviews with the DOC, a staff member and the Environmental Services Manager. [s. 9. (1) 1.]

2. The licensee has failed to ensure that 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.

On September 16, 2021, Inspector #211 observed that the home's basement is a non-residential area. The inspector observed a door leading to the employee lounge in a hallway. The door was closed but unlocked. The door has a key lock. The employee lounge was unsupervised.

On September 20, 2021 at 1230 hours, Inspector #211 observed a door titled "Chute a linge (Laundry chute)" in the basement hallway, slightly opened and a wooden door stopper was placed on the floor preventing the door from latching. This door requires a key to be opened. The room was unsupervised.

On September 22, 2021, Inspector #211 observed from the basement hallway, open double doors going into an unsupervised purchasing room filled with equipment. Furthermore, Inspector #211 observed two sets of opened double side doors located at the far-left side end of the purchasing room leading directly to the exterior parking lot and a high traffic street. This area was unsupervised. Furthermore, the door leading to the employee lounge was closed but still unlocked. The employee lounge was unsupervised.

The Environmental Services Manager acknowledged that the doors from the staff lounge and the purchasing room should be closed and locked. The Environmental Services Manager stated that the shipping and receiving area located in the far left-side end of the

purchasing room have two sets of double doors going directly outside of the home and that the rooms' interior double doors should be closed and locked. However, the exterior double doors were kept opened during the summer and periods of hot weather because the two compressors located in between the interior and exterior set of double doors radiate too much heat.

The Environmental Services Manager stated that the door #001 "Chute a linge (Laundry chute)" should be closed and locked and the employees were not allowed to place a wooden door stopper to prevent the door from latching.

As such, there was a potential safety risk for residents when non-residential area doors were kept unlocked and or opened if a resident was inadvertently brought down by the elevator to the basement.

Sources: Inspector #211 observation of the home's basement and the basement's doors. Interview with the Environmental Services Manager. [s. 9. (1) 2.]

Additional Required Actions:

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

WN #2: 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 :

1. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that is available in every accessible area if a resident was inadvertently brought down by the elevator to the basement.

A resident's progress notes written on a day in 2021, indicated that while the resident was inside the elevator, the resident was inadvertently brought down to the basement.

The Environmental Services Manager did not know that the phone located outside from, but next to, the elevators in the basement was not functioning properly nor could they estimate the length of time it was in such state. The phone was previously equipped with a resident-staff communication and response system. On September 28, 2021, the Environmental Services Manager stated that the phone in the basement outside from the elevators was repaired and equipped with a resident-staff communication and response system.

As such, this was a potential safety risk for residents if they were inadvertently brought down by the elevator to the basement and they needed to reach a staff member for assistance.

Sources: Review of a resident's health care records. Inspector #211 observation of the home's basement, the phone located outside the elevators in the basement and the phone located outside and next to the elevators in the basement. Interview with the Environmental Services Manager. [s. 17. (1) (e)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. Every licensee of a long-term care home shall ensure that there is a written plan of care for a resident that sets out, clear directions to staff and others who provide direct care to the resident related to a resident's safety device.

Review of a resident's progress notes on a day in 2021, indicated that the resident's safety device was in place and functional. Sixty-seven (67) days later, the resident was found lying on the floor. The progress notes indicated that the resident tried to go to the bathroom by themselves when the resident required assistance.

The Registered Nursing Staff member stated that the resident had the safety device in place on the day of the fall but didn't remember if the safety device rang when the resident was found on the floor. Another Registered Nursing Staff member stated that the resident was able to disconnect the safety device.

The Assistant Director of Care validated that the resident's care plan at the time of the fall did not indicate that the resident had the safety device and this information should have been documented.

As such, the resident's fall risk was increased when the resident's care plan did not set out, clear direction to staff and others who provide direct care that the resident had the safety device.

Sources: Review of a resident's health care records and interviews with two Registered Nursing Staff member and the Assistant Director of Care. [s. 6. (1) (c)]

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 there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
3. Every designated cooling area, if there are any in the home. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was maintained at a minimum

temperature of 22 degrees Celsius in different areas of the home.

Inspector #211 reviewed the licensee's two temperature monitoring and documenting systems for the period of May 15, 2021 to August 7, 2021. The licensee used the Prescott-Russell "Verification de la temperature" sheets from May 15, 2021 to July 11, 2021. On July 13, 2021 at approximately 1400 hours, the temperature monitoring and documenting was replaced with a new remote system titled "blueRover Program" that monitored and documented the home's temperature daily and hourly.

1.Review of the Prescott-Russell "Verification de la temperature" sheets indicated that several areas in the home including resident's bedrooms, dining rooms and common areas were kept under 22 degrees Celsius from May 15, 2021 to June 11, 2021, June 14, 2021 to June 25, 2021, June 28, 2021 to July 9, 2021, July 10, 2021 to July 11, 2021.

2.Review of the Prescott-Russell remote temperature monitoring system titled "blueRover Program" sheets indicated that several areas in the home including resident's bedrooms, dining rooms and common areas were kept under 22 degrees Celsius from July 13, 2021 to August 7, 2021.

The Administrator stated that Prescott & Russell remote temperature monitoring system titled "blueRover Program" sheets indicated to keep the temperature between 20 degrees Celsius to 26 degrees Celsius. The Administrator and others are informed by the remote temperature monitoring system titled "blueRover Program" when the temperature falls below 20 degrees Celsius. The Administrator stated not being aware that the home's temperature should be maintained at a minimum temperature of 22 degrees Celsius as indicated in the O. Reg. 79/10, s. 21. (1). The Environmental Services Manager was also not aware of the 22 C requirement.

The Environmental Services Manager stated that when the temperature in an area of the home was under 20 degrees Celsius or above 26 degrees Celsius the day shift maintenance employee will be notified and corrective actions will be implemented. However, the home does not have maintenance staff on evenings and night shifts in the building. During those times, they do not carry corrective actions when the temperatures are under 20 C.

As such, the residents were potentially at risk to be uncomfortable when the home's temperature was under 22 degrees Celsius.

Sources: Review of Prescott-Russell “Verification de la temperature” and the remote temperature monitoring system titled “blueRover Program” sheets. Interviews with the Environmental Services Manager and the Administrator. [s. 21.] [s. 21.]

2. The licensee has failed to ensure that the temperature was measured and documented in writing, at a minimum at least:
-in two resident bedrooms in different parts of the home,
-in one resident common area on every floor of the home, which may include a lounge, dining area or corridor
-in every designated cooling area,
-once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The home has four dining rooms and twelve lounges. The Environmental Services Manager stated that all these lounges and the dining rooms are considered resident common areas and they are also used as a designated cooling area. The Environmental Services Manager stated that the Bistro, the large lounge from the first floor, and the main entrance in the home are also considered resident common areas and designated has cooling areas.

Review of the Prescott-Russell “Verification de la temperature” sheets from May 15, 2021 to July 11, 2021, indicated the following:

The temperature was not measured and documented in writing in two resident’s bedrooms in different parts of the home, at a minimum at least
-once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, from May 15 to May 23, 2021, June 5 and 6, 12, 13, 26, 27, 2021 and July 10, 12, 2021,
-once every afternoon between 12 p.m. and 5 p.m. and once every evening or night from May 24, 2021 to June 4, 2021 and June 7, 2021 to June 11, 2021 and June 14, 2021 to June 25, June 28, 2021 to July 7, 2021,
-once every afternoon between 12 p.m. and 5 p.m. on July 8, 9 and 11, 2021.

The temperature was not measured and documented in writing,
• in one resident common area also considered as their cooling areas on every floor of the home, and
• in every designated cooling area in the home, at least

-once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night on June 12, 13, 26, 27, 2021 and July 10, 2021,
-once between 12 p.m. and 5 p.m. and once every evening or night from May 15, 2021 to July 7, 2021,
-once every afternoon between 12 p.m. and 5 p.m. on July 8, 9, 11, 2021.

On July 13, 2021, the home replaced the monitoring and documentation of the temperature using the “Verification de la temperature” sheets to the new remote temperature monitoring system titled “blueRover Program” using “UCPR Prescott & Russell” sheets. This new temperature monitoring system monitoring documented the temperature daily and hourly.

The Environmental Services Manager stated that they were unable to find the monitoring and the documentation of the temperature for July 12, 2021. The Environmental Services Manager explained that they stopped monitoring and documenting the temperature using the “Verification de la temperature” sheets when the new remote temperature monitoring system titled “blueRover Program” was implemented in the home. The Environmental Services Manager believed that the new remote temperature monitoring system was initiated on July 12, 2021, but the temperature monitoring was not documented.

Consequently, the temperature was not measured and documented in writing, at a minimum in the following areas of the home as indicated in O. Reg. 79/10, s. 21 (2) 1. 2. 3. And O. Reg. 79/10, s. 21 (3).

There was a risk to resident comfort and safety when the temperatures were not measured and documented in the specified areas of the home during the required time frames.

Sources: Review of Prescott-Russell “Verification de la temperature” and the remote temperature monitoring system titled “blueRover Program” sheets. Interviews with the Environmental Services Manager and the Administrator. [s. 21. (2) 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 the home is maintained at a minimum temperature of 22 degrees Celsius,
-to that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home.
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.
3. Every designated cooling area, if there are any in the home, and
-to ensure that the temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control practice program.

The staff did not sanitize the resident's hands before their meal and another staff member did not sanitize their own hands prior to assisting residents with their meals.

On September 2, 2021, during lunch time, Inspectors #211 and #720492 observed that two staff members did not assist a resident with hand hygiene prior to the start of their meal nor when entering the dining room. Two Registered Nursing staff members validated that the resident's hands were not sanitized prior to the start of their meal.

Furthermore, Inspectors #211 and #720492 observed two staff members did not assist another resident with hand hygiene prior to the start of their meal nor when entering the dining room. The Registered Nursing staff member validated that the resident's hands were not sanitized prior starting their meal.

Moreover, Inspectors #211 and #720492 observed that another staff member did not perform hand hygiene prior to assisting two other residents with their meal. The staff member's hands were not sanitized in-between both residents prior assisting them with their meals. The staff member validated that their own hands were not sanitized before assisting residents with their meals.

As such, residents were placed at risk for transmission of infection when the staff did not assist residents with their hand hygiene before their meal and when a staff member's hands were not cleaned or sanitized before assisting residents with their meals.

Sources: Inspectors #211and #720492's observations. Interviews with four staff members. [s. 229. (4)]

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 all staff participate in the implementation of the program, to be implemented voluntarily.

Issued on this 26th day of October, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Name of Inspector (ID #) / Nom de l’inspecteur (No) :	JOELLE TAILLEFER (211)
Inspection No. / No de l’inspection :	2021_831211_0014
Log No. / No de registre :	009290-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 21, 2021
Licensee / Titulaire de permis :	United Counties of Prescott and Russell 59 Court Street, Box 304, L'orignal, ON, K0B-1K0
LTC Home / Foyer de SLD :	Residence Prescott et Russell 1020 Cartier Boulevard, Hawkesbury, ON, K6A-1W7
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Alexandre Gorman

To United Counties of Prescott and Russell, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère 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

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

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.

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).

Order / Ordre :

The licensee shall ensure that:

1-The door at the end of the basement hallway leading to the stairwell is kept closed and locked, equipped with a door access control system that is kept on at all times, and 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.

2-The doors leading to the laundry chute, the purchasing room and the employee lounge from the basement hallway are to be kept closed and locked when these areas are not immediately supervised to restrict resident access to these non-residential areas. Additionally, the purchasing room doors leading to the outside of the home must be kept closed and locked when not supervised.

3-Ensure that all staff members of the long-term care (LTC) home are re-educated on the importance to keep doors closed and locked when these areas are not immediately supervised to restrict resident access to these non-residential areas.

4-Conduct bi-weekly audits for all doors leading to non-residential areas in the basement to ensure they are kept closed and locked when they are not supervised until December 27, 2021.

5-Document, implement and re-evaluate corrective actions to address any identified deficiencies during the bi-weekly audits.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents do not have access to all non-residential areas.

Every licensee of a long-term care home shall ensure that the following rules are complied with where all doors leading to non-residential areas 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.

Inspector #211 observed that the home has two side by side elevators. These two elevators are accessible from the third floor to the basement level. Both elevators are equipped with a keypad to restrict resident access to the basement. A code needs to be activated on the keypad to send the elevator to the basement. The basement level was identified as a non-residential area of the home. It is noted that, when the elevators are signaled from the basement to go to the basement level, any person who is in the elevator at the time of the signaling, will be brought to the basement and have access to the non-residential areas in the basement.

Inspector #211 reviewed the home's policy #650.91 titled "Ascenseur" dated June 2016 that was placed on the wall between both elevators in the basement. The Policy's documentation written in French indicated "When a staff member pressed the button to request the elevator to the basement, the staff must wait for the arrival of the elevator to ensure that a resident, unwittingly, was brought down to the basement".

A resident's progress notes written on a day in 2021, indicated that the resident was brought down to the basement, then climbed up the stairs from the basement to the first floor. The resident was found by a staff member on the first floor.

On September 16, 2021, Inspector #211 observed that the home's basement is deemed to be a non-residential area. The inspector noted that at the end of a hallway there was an unlocked door leading to a stairwell leading to the first floor that was not equipped with a door access control system nor equipped with an audible door alarm. On September 22, 2021, the door leading to the stairwell was still closed but unlocked.

Interview with a staff member stated that twice this year two unidentified residents were inadvertently brought down to the basement by the elevator. Moreover, a similar incident occurred approximately six months ago.

The DOC stated that the resident's incident occurred because while the resident was in the elevator, a staff member signaled the elevator from the basement. The unknown employee left the area instead of waiting for the elevator doors to open. The resident climbed the stairs from the basement to the first floor until the resident was found by an employee. The DOC stated that the resident was able to use a mobility device independently and take the elevator.

The Environmental Services Manager acknowledged that the door does not have a locking mechanism and that it should be kept closed and locked, equipped with a door access control system that is always kept on and equipped with an audible door alarm as it leads to a stairwell.

As such, there was a potential safety risk for the resident as the resident was able to access non-residential areas of the home.

Sources: Review of a resident's health care records and the home's policy #650.91 titled "Ascenseur" dated June 2016. Inspector #211 observation of the home's basement and the basement's doors. Interviews with the DOC, a staff member and the Environmental Services Manager. [s. 9. (1) 1.] (211)

2. The licensee has failed to ensure that 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.

On September 16, 2021, Inspector #211 observed that the home's basement is a non-residential area. The inspector observed a door leading to the employee lounge in a hallway. The door was closed but unlocked. The door has a key lock. The employee lounge was unsupervised.

On September 20, 2021 at 1230 hours, Inspector #211 observed a door titled "Chute a linge (Laundry chute)" in the basement hallway, slightly opened and a wooden door stopper was placed on the floor preventing the door from latching. This door requires a key to be opened. The room was unsupervised.

On September 22, 2021, Inspector #211 observed from the basement hallway,

open double doors going into an unsupervised purchasing room filled with equipment. Furthermore, Inspector #211 observed two sets of opened double side doors located at the far-left side end of the purchasing room leading directly to the exterior parking lot and a high traffic street. This area was unsupervised. Furthermore, the door leading to the employee lounge was closed but still unlocked. The employee lounge was unsupervised.

The Environmental Services Manager acknowledged that the doors from the staff lounge and the purchasing room should be closed and locked. The Environmental Services Manager stated that the shipping and receiving area located in the far left-side end of the purchasing room have two sets of double doors going directly outside of the home and that the rooms' interior double doors should be closed and locked. However, the exterior double doors were kept opened during the summer and periods of hot weather because the two compressors located in between the interior and exterior set of double doors radiate too much heat.

The Environmental Services Manager stated that the door #001 "Chute a linge (Laundry chute)" should be closed and locked and the employees were not allowed to place a wooden door stopper to prevent the door from latching.

As such, there was a potential safety risk for residents when non-residential area doors were kept unlocked and or opened if a resident was inadvertently brought down by the elevator to the basement.

Sources: Inspector #211 observation of the home's basement and the basement's doors. Interview with the Environmental Services Manager. (211)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 27, 2021

Ontario

Ministry of Long-Term Care

Ministère 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

Order # / No d'ordre : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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;

(b) is on at all times;

(c) allows calls to be cancelled only at the point of activation;

(d) is available at each bed, toilet, bath and shower location used by residents;

(e) is available in every area accessible by residents;

(f) clearly indicates when activated where the signal is coming from; and

(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).

Order / Ordre :

The licensee shall ensure that:

The phone located outside from, but next to, the elevators in the basement is equipped with a resident-staff communication and response system that is always available if a resident was inadvertently brought down by the elevator to the basement.

Grounds / Motifs :

1. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that is available in every accessible area if a resident was inadvertently brought down by the elevator to the basement.

A resident's progress notes written on a day in 2021, indicated that while the resident was inside the elevator, the resident was inadvertently brought down to the basement.

The Environmental Services Manager did not know that the phone located outside from, but next to, the elevators in the basement was not functioning properly nor could they estimate the length of time it was in such state. The phone was previously equipped with a resident-staff communication and response system. On September 28, 2021, the Environmental Services Manager stated that the phone in the basement outside from the elevators was repaired and equipped with a resident-staff communication and response system.

As such, this was a potential safety risk for residents if they were inadvertently brought down by the elevator to the basement and they needed to reach a staff member for assistance.

Sources: Review of a resident's health care records. Inspector #211 observation of the home's basement, the phone located outside the elevators in the basement and the phone located outside and next to the elevators in the basement. Interview with the Environmental Services Manager. (211)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 27, 2021

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 Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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 Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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 des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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 des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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 21st day of October, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Joelle Taillefer

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