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

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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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 17, 2015	2015_381592_0022	O-002708-15	Critical Incident System

Licensee/Titulaire de permis

BRUYERE CONTINUING CARE INC.
43 BRUYERE STREET OTTAWA ON K1N 5C8

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

RESIDENCE SAINT- LOUIS
879 CHEMIN PARC HIAWATHA OTTAWA ON K1C 2Z6

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

MELANIE SARRAZIN (592)

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 08, 09, 10 , 11, 14, 15, 16, 17, 18 and 21, 2015.

During the course of the inspection, the inspector(s) spoke with The Administrator, the Occupational Therapist (OT), the on call Supervisor , Registered Nurses (RN), a Registered Practical Nurse (RPN), a Personal Support Worker (PSW) and a family member.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Personal Support Services
Reporting and Complaints
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **1 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. 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. O.Reg79/10, s. 230 (2)(4) vii, states that every licensee of a long-term care home shall ensure that the emergency plans for the home are in writing. The licensee shall ensure that the emergency plans provide for the following: situations involving a missing resident. Furthermore,

O Reg. 79/10 s.8 (1)(b) stipulates that 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 to be complied with.

On September 4, 2015, the policy entitled Code Yellow: Missing Person, issued on December 2013 and reviewed on November 2014, was in place. This policy provided directions to staff regarding the steps to follow when a person was considered missing, which the policy defined as "a person not being where you expected them to be". The policy also pointed out that situations which endangered the resident if not located (e.g. a person requiring medications to survive) or known high risk diagnosis were to be viewed as critical and a Code Yellow was to be announced once confirmation was received that a resident was not where you expected them to be.

According to the Code Yellow procedure in place on September 4, 2015, upon hearing the Code Yellow announcement, identified staff was to conduct various site searches and alert the Emergency Response Team & Security. If the resident was not found, 911 was to be called, the police was to take over the search and the Code Yellow was to be terminated while staff continued to liaise with police until the resident was found.

On a specific date in September 2015, the licensee failed to comply with its policy entitled Code Yellow: Missing Person when it was confirmed that Resident #001 did not return from an authorized leave within the expected time frame, therefore, he/she was not according to the home's Code Yellow Policy where he/she was expected to be. The following is a summary of the information gathered about the incident:

16:00 hours: RPN #100 went to Resident #001's room to administer his/her 16:00 medications including the monitoring of his/her blood sugar and observed that Resident #001 was not in his/her room as expected. RPN #100 checked the sign Out/In Book, the daily report, the charting from days but there was nothing indicating Resident #001 whereabouts. All she knew was that Resident #001 was last seen at 12:00 at lunch time

for the administration of his/her medications and that he/she was mentally capable, propelling an electric wheelchair and needed treatment for a wound and taking medications for his/her medical conditions. Resident #001 was known to have regular habits to go outside non-accompanied, with his/her electric wheelchair without recording his/her outings in the sign Out/In book. Resident #001 was also known to rarely informed staff members of his/her whereabouts.

On or about 16:20 hours: RN #101 after being made aware of Resident #001 missing, gave instructions to RPN #100 to wait before activating the Code Yellow Policy as RN #101 was expecting Resident #001 to return to the home for supper around 17:00, as per his/her past habits.

Between 17:30 and 17:45 hours: Upon the non-return from Resident #001, RPN #100 was instructed by RN #101 to contact the Resident's family members. RPN #100 attempted to contact by phone the Resident's family members and left voice messages, requesting the family to call back the home to discuss Resident #001's whereabouts. RPN #100 was unable to reach one family member as the phone number was no more in service.

On or about 19:00 hours: One family member(POA) returned the home's phone call and confirmed with PRN #100, that the family were not with Resident #001. RN #101 who was passing by took the phone and was told by Resident #001's family member to do what was necessary to find his/her relative. After hanging up the phone, RN #101 told RPN #100 to not contact the Police Department for now, as Resident #001 was known to not notifying staff of his/her whereabouts. RN #101 gave instructions to RPN #100 to conduct a search of a specific floor area where resident #001's bedroom was located with the assistance of PSW's. After the completion of the search, Resident #001 was not found.

At approximately 20:00 hours: RPN #100 ask the security guard to do an external search of the home surroundings to try to find Resident #001. The security guard used his personal car to perform the exterior search in the dark, getting out of the vehicle occasionally and shining his high-beam into the darkness.

At approximately 20:30 hours: The security guard came back and reported to RPN #100 and RN #101 that the external search had been completed but Resident #001 had not been found. In the meantime, the on call supervisor was informed by RN #101 that

Resident #001 was not seen since 16:00. The on call supervisor gave instructions to RN #101 to conduct a full search of the home's ground and then if Resident #001 was not found on site and had not return to the home, to contact the police department at 21:30.

After receiving the instructions from the On call supervisor, RN #101 told the security guard that the Police department would not be contacted until 21:30, since Resident #001 was a grown adult with sound mind.

On or about 21:30 hours: RN #101 contacted the Ottawa Police Department to inform them of the Resident #001 being missing.

Between 21:45 and 22:00 hours: The on call supervisor contacted the off-site clinical person on call to inform her of Resident #001 being missing.

At approximately 22:20 hours: two Police officers arrived at the home and interviews were conducted with the home staff members.

At approximately 23:15 hours: five Police officers took charge of the entire internal building search with the home's staff members to try to locate Resident #001. Once the internal search had been completed, an external search was conducted by the Police officers.

At approximately 01:00: Resident #001 was found deceased by the Ottawa Police officers, outside, on the home's property.

Upon review of Resident #001's health care record, it is noted that resident was capable and was making his/her own decision.

No documentation was found in the progress notes for a specified period in 2015, when Resident #001 was leaving the unit. No documentation was found in the current plan of care regarding the pattern of leave and permission to go out unaccompanied. The plan of care did not reference the use of a electric wheelchair and Resident #001 capacity to maneuver it himself/herself.

On September 09, 2015, the Administrator told inspector #592 that she would have expected the staff to activate the Code Yellow Policy when the resident was noted to be missing at 16:00. [s. 8. (1) (b)]

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 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).

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. On a specific date in September 2015, the licensee failed to comply with its written plan of care, setting clear directions to staff and others when providing direct care to Resident #001.

The following is a summary of the information gathered about the incident:

16:00 hours: RPN #100 went to Resident #001's room to administer his/her 16:00 medications including the monitoring of his/her blood sugar and observed that Resident #001 was not in his/her room as expected. RPN #100 checked the sign Out/In Book, the daily report, the charting from days but there was nothing indicating Resident #001 whereabouts. All she knew was that Resident #001 was last seen at 12:00 at lunch time for the administration of his/her medications and that he/she was mentally capable,

propelling an electric wheelchair and needed treatment for a wound and taking medications for his/her medical conditions. Resident #001 was known to have regular habits to go outside non-accompanied, with his/her electric wheelchair without recording his/her outings in the sign Out/In book. Resident #001 was also known to rarely informed staff members of his/her whereabouts.

On or about 16:20 hours: RN #101 after being made aware of Resident #001 missing, gave instructions to RPN #100 to wait before activating the Code Yellow Policy as RN #101 was expecting Resident #001 to return to the home for supper around 17:00, as per his/her past habits.

Between 17:30 and 17:45 hours: Upon the non-return from Resident #001, RPN #100 was instructed by RN #101 to contact the Resident's family members. RPN #100 attempted to contact by phone the Resident's family members and left voice messages, requesting the family to call back the home to discuss Resident #001's whereabouts. RPN #100 was unable to reach one family member as the phone number was no more in service.

On or about 19:00 hours: One family member(POA) returned the home's phone call and confirmed with PRN #100, that the family were not with Resident #001. RN #101 who was passing by took the phone and was told by Resident #001's family member to do what was necessary to find his/her relative. After hanging up the phone, RN #101 told RPN #100 to not contact the Police Department for now, as Resident #001 was known to not notifying staff of his/her whereabouts. RN #101 gave instructions to RPN #100 to conduct a search of a specific floor area where resident #001's bedroom was located with the assistance of PSW's. After the completion of the search, Resident #001 was not found.

At approximately 20:00 hours: RPN #100 ask the security guard to do an external search of the home surroundings to try to find Resident #001. The security guard used his personal car to perform the exterior search in the dark, getting out of the vehicle occasionally and shining his high-beam into the darkness.

At approximately 20:30 hours: The security guard came back and reported to RPN #100 and RN #101 that the external search had been completed but Resident #001 had not been found. In the meantime, the on call supervisor was informed by RN #101 that Resident #001 was not seen since 16:00. The on call supervisor gave instructions to RN

#101 to conduct a full search of the home's ground and then if Resident #001 was not found on site and had not return to the home, to contact the police department at 21:30.

After receiving the instructions from the On call supervisor, RN #101 told the security guard that the Police department would not be contacted until 21:30, since Resident #001 was a grown adult with sound mind.

On or about 21:30 hours: RN #101 contacted the Ottawa Police Department to inform them of the Resident #001 being missing.

Between 21:45 and 22:00 hours: The on call supervisor contacted the off-site clinical person on call to inform her of Resident #001 being missing.

At approximately 22:20 hours: two Police officers arrived at the home and interviews were conducted with the home staff members.

At approximately 23:15 hours: five Police officers took charge of the entire internal building search with the home's staff members to try to locate Resident #001. Once the internal search had been completed, an external search was conducted by the Police officers.

At approximately 01:00: Resident #001 was found deceased by the Ottawa Police officers, outside, on the home's property.

Resident #001 was known to have regular habits to go outside non-accompanied, with his/her power wheelchair without recording his/her outings in the sign Out/In book. Resident #001 was also known to rarely informed staff members of his/her whereabouts.

Upon review of Resident #001's Health Care Records, it is noted that resident was diagnosed with several medical conditions and it was further noted that Resident #001 was capable and was making his/her own decision.

No clear directions were found in the current plan of care regarding the permission to go out unaccompanied which as per staff interviews, Resident #001 was doing frequently.

No clear directions were found in the current plan of care for the use of an electric wheelchair and Resident #001 capacity to maneuver it himself/herself.

No clear directions were found in the current Plan of care for Resident #001's outing business, the length of time allowed and emergency procedures upon the non-return of Resident.

The plan of care did not provide clear directions to staff and others who provided him with direct care because the plan of care did not set out:

(a). Resident #001’s history of outings
(b). How to monitor and manage Resident #001’s outing behaviours
(c). Resident #001's using an electric wheelchair and capacity to maneuver it himself/herself.

On September 09, 2015, the Administrator told inspector #592 that she was not able to find any clear directions in the current plan of care for Resident #001 relating to the use of an electric wheelchair and outings. [s. 6. (1) (c)]

2. The licensee failed to comply with s.6(10)(b) in that it failed to ensure the plan of care was reassessed and revised when care needs changed or care set out in the plan of care is no longer necessary.

The written plan of care for mobility indicates that Resident #001 requires no assistance when ambulating and that Resident #001 continues to be fairly independent and that he/she drives his/her own car on personal outing each week.

The plan of care was not reviewed and revised when Resident #001’s mobility needs changed, and when Resident #001 began using an electric wheelchair for mobility. The plan of care does not contain any information about mobility devices. [s. 6. (10) (b)]

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 residents who are permitted to go on outings and resident using a mobility device that sets the planned care with clear direction to staff members, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure to inform the Director immediately, in as much detail as is possible in the circumstances, of a resident who is missing for three hours or more, followed by the report required under subsection (4):

On a specific date in September 2015, Resident #001 was deemed as missing by RPN #100.

At approximately 01:00 , Resident #001 was found deceased by the Ottawa Police officers, outside, on the home's property.

Upon review of the home's Critical incident report submitted on September 18, 2015, it indicated that the incident occurred on a specific date in September 2015.

Upon review of the MOHTLC Incident Report, it indicated that the home contacted the after-hours CIATT line on another specific date in September 2015, which was not immediately.

During a meeting with the Administrator on September 09, 2015, she told inspector #592 that she was aware that there was a delay for reporting to the Director. [s. 107. (1)]

Issued on this 27th day of November, 2015

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

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELANIE SARRAZIN (592)
Inspection No. / No de l'inspection :	2015_381592_0022
Log No. / Registre no:	O-002708-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 17, 2015
Licensee / Titulaire de permis :	BRUYERE CONTINUING CARE INC. 43 BRUYERE STREET, OTTAWA, ON, K1N-5C8
LTC Home / Foyer de SLD :	RESIDENCE SAINT- LOUIS 879 CHEMIN PARC HIAWATHA, OTTAWA, ON, K1C-2Z6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Chantal Cameron

To BRUYERE CONTINUING CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to include the following:
Re-education of all staff members for the Code Yellow Policy/emergency plan missing person. This re-education needs to be documented which will include, but is not limited to the following components:

1. Identify all residents in the home who are permitted to leave the home, unaccompanied.
2. Assess and/or reassess the needs of residents permitted to leave the home unaccompanied, review and, if necessary, revise the plan of care based on the assessed needs.
3. Update and revise the "Code Yellow " policy to clarify procedures and staff interventions when mentally capable residents does not return to the home within set time frames.
4. Train all staff members to ensure adherence to the updated/revised Code Yellow Policy
5. Develop an ongoing process for monitoring and evaluating the effectiveness of the Code Yellow Policy to ensure staff have the knowledge and skills required when a resident is missing.

The plan shall identify the time line for completing the tasks and who will be responsible for completing those tasks.

In the event of a missing resident/person, the policy is to be immediately implemented in it's entirely.

This plan must be submitted in writing to Melanie Sarrazin, LTCH Inspector at 347 Preston Street, 4th floor, Ottawa, Ontario K1S 3J4 or by fax at 1-613-569-9670 on or before December 02, 2015.

Grounds / Motifs :

1. 1. O.Reg79/10, s. 230 (2)(4) vii, states that every licensee of a long-term care home shall ensure that the emergency plans for the home are in writing. The licensee shall ensure that the emergency plans provide for the following: situations involving a missing resident. Furthermore,

O Reg. 79/10 s.8 (1)(b) stipulates that 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 to be complied with.

On September 4, 2015, the policy entitled Code Yellow: Missing Person, issued on December 2013 and reviewed on November 2014, was in place. This policy provided directions to staff regarding the steps to follow when a person was considered missing, which the policy defined as "a person not being where you expected them to be". The policy also pointed out that situations which endangered the resident if not located (e.g. a person requiring medications to survive) or known high risk diagnosis were to be viewed as critical and a Code Yellow was to be announced once confirmation was received that a resident was not where you expected them to be.

According to the Code Yellow procedure in place on September 4, 2015, upon hearing the Code Yellow announcement, identified staff was to conduct various site searches and alert the Emergency Response Team & Security. If the resident was not found, 911 was to be called, the police was to take over the search and the Code Yellow was to be terminated while staff continued to liaise with police until the resident was found.

On a specific date in September 2015, the licensee failed to comply with its policy entitled Code Yellow: Missing Person when it was confirmed that Resident #001 did not return from an authorized leave within the expected time frame, therefore, he/she was not according to the home's Code Yellow Policy where he/she was expected to be.
The following is a summary of the information gathered about the incident:

16:00 hours: RPN #100 went to Resident #001's room to administer his/her 16:00 medications including the monitoring of his/her blood sugar and observed that Resident #001 was not in his/her room as expected. RPN #100 checked the sign Out/In Book, the daily report, the charting from days but there was nothing indicating Resident #001 whereabouts. All she knew was that Resident #001 was last seen at 12:00 at lunch time for the administration of his/her medications and that he/she was mentally capable, propelling an electric wheelchair and needed treatment for a wound and taking medications for his/her medical conditions. Resident #001 was known to have regular habits to go outside non-accompanied, with his/her electric wheelchair without recording his/her outings in the sign Out/In book. Resident #001 was also known to rarely informed staff members of his/her whereabouts.

On or about 16:20 hours: RN #101 after being made aware of Resident #001 missing, gave instructions to RPN #100 to wait before activating the Code Yellow Policy as RN #101 was expecting Resident #001 to return to the home for supper around 17:00, as per his/her past habits.

Between 17:30 and 17:45 hours: Upon the non-return from Resident #001, RPN #100 was instructed by RN #101 to contact the Resident's family members. RPN #100 attempted to contact by phone the Resident's familly members and left voice messages, requesting the familly to call back the home to discuss Resident #001's whereabouts. RPN #100 was unable to reach one familly member as the phone number was no more in service.

On or about 19:00 hours: One family member(POA) returned the home's phone call and confirmed with PRN #100, that the family were not with Resident #001. RN #101 who was passing by took the phone and was told by Resident #001's family member to do what was necessary to find his/her relative. After hanging up the phone, RN #101 told RPN #100 to not contact the Police Department for now, as Resident #001 was known to not notifying staff of his/her whereabouts. RN #101 gave instructions to RPN #100 to conduct a search of a specific floor area where resident #001's bedroom was located with the assistance of PSW's. After the completion of the search, Resident #001 was not found.

At approximately 20:00 hours: RPN #100 ask the security guard to do an external search of the home surroundings to try to find Resident #001. The security guard used his personal car to perform the exterior search in the dark, getting out of the vehicle occasionally and shining his high-beam into the darkness.

At approximately 20:30 hours: The security guard came back and reported to RPN #100 and RN #101 that the external search had been completed but Resident #001 had not been found. In the meantime, the on call supervisor was informed by RN #101 that Resident #001 was not seen since 16:00. The on call supervisor gave instructions to RN #101 to conduct a full search of the home's ground and then if Resident #001 was not found on site and had not return to the home, to contact the police department at 21:30.
After receiving the instructions from the On call supervisor, RN #101 told the security guard that the Police department would not be contacted until 21:30,

since Resident #001 was a grown adult with sound mind.

On or about 21:30 hours: RN #101 contacted the Ottawa Police Department to inform them of the Resident #001 being missing.

Between 21:45 and 22:00 hours: The on call supervisor contacted the off-site clinical person on call to inform her of Resident #001 being missing.

At approximately 22:20 hours: two Police officers arrived at the home and interviews were conducted with the home staff members.

At approximately 23:15 hours: five Police officers took charge of the entire internal building search with the home's staff members to try to locate Resident #001. Once the internal search had been completed, an external search was conducted by the Police officers.

At approximately 01:00: Resident #001 was found deceased by the Ottawa Police officers, outside, on the home's property.

Upon review of Resident #001's health care record, it is noted that resident was capable and was making his/her own decision.

No documentation was found in the progress notes for a specific time period when Resident #001 was leaving the unit. No documentation was found in the current plan of care regarding the pattern of leave and permission to go out unaccompanied. The plan of care did not reference the use of a electric wheelchair and Resident #001 capacity to maneuver it himself/herself.

On September 09, 2015, the Administrator told inspector #592 that she would have expected the staff to activate the Code Yellow Policy when the resident was noted to be missing at 16:00. [s. 8. (1) (b)] (592)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 21, 2016

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 17th day of November, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Melanie Sarrazin

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