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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 31, 2014	2014_189120_0048	H-000522-14	Critical Incident System

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

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

THE VILLAGE OF TANSLEY WOODS
4100 Upper Middle Road, BURLINGTON, ON, L7M-4W8

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

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

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 16 and 25, 2014

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Environmental Services, registered and non-registered staff.

During the course of the inspection, the inspector(s) tested ground level courtyard doors in two home areas, observed the fences in two courtyards, tested the doors between the retirement home and long term care home and the main doors into the long-term care home, reviewed the home's policies and procedures regarding the use of the courtyards/balconies and missing residents.

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

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the sliding glass doors between the retirement home side and the long-term care home side were;

i. kept closed and locked,
ii. equipped with a door access control system that was kept on at all times, and
iii. equipped with an audible door alarm that allowed calls to be canceled only at the point of activation and was connected to the resident-staff communication and response system

The licensee also failed to ensure that the main entry doors into the long-term care home from the outdoors was;

iii. equipped with an audible door alarm that allowed calls to be canceled only at the point of activation and was connected to the resident-staff communication and response system.

A) During the inspection on July 16, 2014, the sliding glass doors were unlocked and the key pad responsible for controlling the doors was on by-pass, allowing anyone to enter or exit just by approaching the doors. Motion sensors were mounted above the doors which allowed the doors to slide open. Once through the sliding doors, there were two exits to the outdoors and to a busy street. The licensee identified in early June 2014 that a malfunction had occurred with the door system, but neither of the installers of the two systems (door and key pad release) could agree on the cause of the malfunction. Both installers met at the home on July 21, 2014 and the door access control system replaced. The key pad function and doors were tested and found locked during the inspection on July 25, 2014.

B) According to the Director of Environmental Services, between April 16, 2014 and May 9th, 2014, the sliding doors were locked and the door locking mechanism (key Pad) placed out of commission due to an outbreak in the long term care home. According to front line staff, the doors were breached and unlocked on several occasions on the retirement side, either by staff or visitors, by pushing on an emergency release mechanism. In particular, on April 21, 2014, a side glass panel (one was located on either side of the sliding glass doors) was found to be ajar or unlocked by two staff members. One of the staff members closed the side panel and re-secured the doors. When the doors were tested on July 25, 2014, an emergency release panel was easily pushed on the retirement side allowing the side panels to open. Registered staff, who were given the task of checking exit doors each night did not check the sliding doors, particularly on April 21, 2014. No system was put in place to ensure the doors were kept locked or that unlocked doors would alarm to alert staff.

C) On July 25, 2014, the sliding glass doors between the retirement home and the long-term care home were tested by preventing them from closing for over 2 minutes. They were not connected to the resident-staff communication and response system and the Nelson home area nurse's station did not have a visual enunciator installed on

the panel for the sliding doors.

D) On July 25, 2014, the main foyer doors leading into the long-term care home from the outdoors were tested by holding them open for more than 60 seconds. The interior door did not trigger an adequate alarm at the door (key pad beeped quietly but did not alarm), the visual enunciator at the nurse's station panel or the audio for the resident-staff communication and response system. [s. 9(1)]

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. 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. The licensee failed to comply with their written policy titled "Safe Outdoor Living" (06-35) on the use of their outdoor space, specifically their outdoor courtyards, which included when to keep the doors locked or unlocked to permit or restrict unsupervised access to those areas by residents.

The home's policy states that "team members will monitor outdoor living space when the doors are unlocked by surveying the area every 2 hours or more often as needed", that "doors to secured garden areas will be locked when it is unsafe" and that "doors will be unlocked for residents between the hours of 0900 and 2100 depending on season". According to the maintenance person, the courtyards were not to be used until May, after they could be cleaned and prepared for use. This was however not specifically identified in the policy.

The maintenance person reported that a sign advising people that the courtyards were closed was placed on the courtyard doors in April 2014 after a storm hit the Burlington area. The courtyard fences had several panels blown out by the wind storm. The fence panels were not repaired until June 8, 2014. A registered staff member for one of the identified home areas unsecured the door access control system to the courtyard on a specific date in April 2014 after 5 p.m. for a family member and a resident. The staff member was aware of the missing fence panels but assumed that because a family member was present, the resident who was going out with them would remain safe. They did not recall seeing any signs and neither did several other staff members who worked on the identified date in April. Before the family member and resident returned inside, the staff member left the home and forgot to re-set the door access control system and failed to inform other staff members that someone was outside and that the door was not secured completely. At approximately 6:30 p.m., a resident disappeared. It was suspected, although not confirmed that the resident exited the home via the courtyard door and went through an unsecured fence.

The staff member admitted that they should have been more diligent in ensuring that the doors were adequately locked once the family member returned inside with a resident. The courtyard was not monitored for other residents who may have entered the courtyard while the family member was in the courtyard. The team members were not diligent in following the policy. [s. 8(1)]

Issued on this 31st day of July, 2014

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

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) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2014_189120_0048
Log No. / Registre no:	H-000522-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 31, 2014
Licensee / Titulaire de permis :	OAKWOOD RETIREMENT COMMUNITIES INC. 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	THE VILLAGE OF TANSLEY WOODS 4100 Upper Middle Road, BURLINGTON, ON, L7M-4W8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JO-ANNA GURD

To OAKWOOD RETIREMENT COMMUNITIES INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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. 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 prepare and submit a plan that summarizes the following;

1. When the sliding glass doors between the retirement home and the long-term care home will be equipped with an audible door alarm and connected to the resident-staff communication and response system.
2. When the front interior main door will be functioning adequately so that the door can trigger an alarm at the door, the visual enunciator at the nurse's station and when the audio will function for the resident-staff communication and response system.
3. How the licensee intends to ensure that doors to non-LTC home areas and doors to unsecured outdoor areas will be kept closed and locked when necessary and that the access door control systems and the connection to the resident-staff communication and response system is in good working order.

The plan shall be submitted to Bernadette Susnik via email to Bernadette.susnik@ontario.ca by August 18, 2014. The plan shall be implemented by September 30, 2014.

Grounds / Motifs :

1. The licensee failed to ensure that the sliding glass doors between the retirement home side and the long-term care home side were;

i. kept closed and locked,
ii. equipped with a door access control system that was kept on at all times, and
iii. equipped with an audible door alarm that allowed calls to be canceled only at the point of activation and was connected to the resident-staff communication and response system

The licensee also failed to ensure that the main interior entry door into the long-term care home from the outdoors was;

iii. equipped with an audible door alarm that allowed calls to be canceled only at the point of activation and was connected to the resident-staff communication and response system.

B) According to the Director of Environmental Services, between April 16, 2014 and May 9th, 2014, the sliding doors were locked and the door locking

mechanism (key Pad) placed out of commission due to an outbreak in the long term care home. According to front line staff, the doors were breached and unlocked on several occasions on the retirement side, either by staff or visitors, by pushing on an emergency release mechanism. In particular, on April 21, 2014, a side glass panel (one was located on either side of the sliding glass doors) was found to be ajar or unlocked by two staff members. One of the staff members closed the side panel and re-secured the doors. When the doors were tested on July 25, 2014, an emergency release panel was easily pushed on the retirement side allowing the side panels to open. Registered staff, who were given the task of checking exit doors each night did not check the sliding doors, particularly on April 21, 2014. No system was put in place to ensure the doors were kept locked or that unlocked doors would alarm to alert staff.

C) On July 25, 2014, the sliding glass doors between the retirement home and the long-term care home were tested by preventing them from closing for over 2 minutes. They were not connected to the resident-staff communication and response system and the Nelson home area nurse's station did not have a visual enunciator installed on the panel for the sliding doors.

D) On July 25, 2014, the main foyer doors leading into the long-term care home from the outdoors were tested by holding them open for more than 60 seconds. The interior door did not trigger an adequate alarm at the door (key pad beeped quietly but did not alarm), the visual enunciator at the nurse's station panel or the audio for the resident-staff communication and response system. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2014

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 31st day of July, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BERNADETTE SUSNIK

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