



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

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

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

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton, ON L8P 4Y7

Bureau régional de services de Hamilton
119, rue King Ouest, 11^{ème} étage
Hamilton, ON L8P 4Y7

**Ministère de la Santé et des Soins de
longue durée**

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

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Licensee Copy/Copie du Titulaire Public Copy/Copie Public

Date of inspection/Date de l'inspection 25 February 2011	Inspection No/ d'inspection 2011_127_2841_24Feb163123	Type of Inspection/Genre d'inspection Critical Incident # H-00316
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Licensee/Titulaire
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 Wentworth Heights, 1620 Upper Wentworth Street, Hamilton ON L9B 2W3

Name of Inspector(s)/Nom de l'inspecteur(s)
Richard Hayden, Long Term Care Homes Inspector – Environmental Health #127

Inspection Summary / Sommaire d'inspection

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

During the course of the inspection, the inspector spoke with the QI Nurse, registered and non-registered nursing staff, administrative staff, maintenance person and residents.

During the course of the inspection, the inspector reviewed inspected windows in all resident home areas.

The following Inspection Protocols were used during this inspection:

- Safe and Secure Home

Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN
2 CO

NON-COMPLIANCE / Non-respectés
Definitions/Définitions

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

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Non-compliance with requirements under the *Long-Term Care Homes Act, 2007* (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)

Le suivant constituer un avis d'écrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with O. Reg. 79/10, s. 16:

Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 10 centimetres.

Findings:

1. An identified resident was able to open the window in their room and leave the home.
2. On 24 February 2011, the inspector observed that three windows in the Stonechurch resident home area could be opened more than 10 centimetres. The windows were found in two resident rooms and the lounge area.
3. On 24 February 2011, the inspector observed that all windows in the Carrington, Scotsdale and Rymal resident home areas could be opened more than 10 centimetres.

Windows in all resident home areas were restricted vertically but can be unlatched and laid horizontally to create an opening the size of the entire glider section of the window.

Additional Required Actions:

CO #1 – order will be served on the licensee



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

	<input type="checkbox"/> Licensee Copy/Copie du Titulaire	<input checked="" type="checkbox"/> Public Copy/Copie Public
Name of Inspector:	Richard Hayden	Inspector ID # 127
Log #:	H-00316	
Inspection Report #:	2011_127_2841_24Feb163123	
Type of Inspection:	Critical Incident	
Date of Inspection:	25 February 2011	
Licensee:	Oakwood Retirement Communities Inc. 325 Max Becker Drive, Suite 201, Kitchener ON N2E 4H5	
LTC Home:	The Village of Wentworth Heights 1620 Upper Wentworth Street, Hamilton ON L9B 2W3	
Name of Administrator:	Vanda Koukounakis	

To Oakwood Retirement Communities Inc., you are hereby required to comply with the following orders by the dates set out below:

Order #:	001	Order Type:	Compliance Order, Section 153 (1)(b)
Pursuant to: O. Reg. 79/10, s.16.			
Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 10 centimetres.			



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Order:

The licensee, Oakwood Retirement Communities Inc., shall:

1. Prepare a plan to modify each window at The Village of Wentworth Heights, 1620 Upper Wentworth Street, Hamilton ON that opens to the outdoors and is accessible to residents to ensure the windows cannot be opened more than 10 centimetres.
2. Submit the plan to Richard Hayden, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Hamilton Service Area Office, 119 King Street West, 11th Floor, Hamilton ON L8P 4Y7 or via e-mail at Richard.Hayden@ontario.ca.
3. Implement the plan at The Village of Wentworth Heights, 1620 Upper Wentworth Street, Hamilton ON

Grounds:

On 24 February 2011, the inspector observed that three windows in the Stonechurch resident home area could be opened more than 10 centimetres. Stonechurch resident home area is a secured unit in The Village of Wentworth Heights. An identified resident was able to open the window in their room on this unit and leave the home. The inspector observed that all windows in the Carrington, Scotsdale and Rymal resident home areas could be opened more than 10 centimetres. Windows are restricted vertically but can be unlatched and laid horizontally to create an opening the size of the entire glider section of the window.

This order must be complied with by: 21 April 2011

Order #: 002	Order Type: Compliance Order, Section 153 (1)(a)
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Pursuant to: O. Reg. 79/10, s. 91:

Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

Order:

The licensee, Oakwood Retirement Communities Inc., shall:

1. Keep all hazardous substances at the home inaccessible to residents at all



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times.

2. Except for staff access, keep all doors closed and locked at all times to rooms, closets, cabinets and cupboards where hazardous substances are stored.

Grounds:

The inspector observed two tub rooms were left with the doors propped open in the Rymal resident home area at 1150 hrs on 24 February 2011. No staff members were present in either tub room and bottles of disinfectants were accessible.

This order must be complied with by: Immediately

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this(these) Order(s) in accordance with section 163 of the *Long-Term Care Homes Act, 2007*.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for service for the Licensee.

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

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. The HSARB is an independent group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:



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Direction de l'amélioration de la performance et de la conformité

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

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Issued on this 7th day of April, 2011.	
Signature of Inspector:	
Name of Inspector:	Richard Hayden
Service Area Office:	119 King Street West, 11 th Floor, Hamilton ON L8P 4Y7