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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
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Bureau régional de services d'Ottawa
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 6, 2013	2013_230134_0007	O-000641-13	Follow up

Licensee/Titulaire de permis

CITY OF OTTAWA
Long Term Care Branch, 275 Perrier Avenue, OTTAWA, ON, K1L-5C6

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

GARRY J. ARMSTRONG HOME
200 ISLAND LODGE ROAD, OTTAWA, ON, K1N-5M2

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

COLETTE ASSELIN (134)

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

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The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): August 30, 2013

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Manager of Hospitality Services, Facilities Supervisor, Registered Nurses, Registered Practical Nurses (RPN), Receptionists, Manager of Recreation and Leisure, Physio Assistant (PTA), Housekeeper, Laundry Worker and several Personal Support Workers (PSW)

During the course of the inspection, the inspector(s) toured the 7 levels and the lower level.

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	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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 LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensees failed to comply with the LTCHA, 2007, c.8, s. 5, in that the home is not a safe and secured environment for its residents since the recently installed door alarms on doors leading to stairwells or unsecured areas outside the home are not responded too, in a timely manner.

As a result of inspection #2013_204133_0001 log #O-002083 (elopement of resident) the home was issued a compliance order related to the front door and 24 other resident accessible doors that lead to stairways or to unsecured outside areas, which were not alarmed as required. A follow-up inspection #2013_230134_0005 log # O-000035-13, was conducted July 9, 2013, which resulted in a second non-compliance order. The compliance date was July 12, 2013.

On August 30, 2013 a follow-up inspection to order #001, was conducted and the order was found to be compliant as it relates to the installation of door alarms on all resident accessible doors that lead to stairways and unsecured outside areas. However, a number of issues related to the installation of the door alarms require further action.

Inspector #134 toured units, 1, 2, 3, 4 and 5 accompanied by the Facility Supervisor between 9:45 and 11:15. The stairwell doors were propped open for a 15-second delay, which activated an audible door alarm. The door alarm is connected to an audio visual enunciator that is connected to the nurses' station on 3rd, 4th and 5th levels' nearest to the door and has a manual reset switch at each door. The alarmed doors on the ground, first and 2nd level are connected to the resident-staff communication and response system (pagers) on the 2nd floor.

During the tour on Level 1- the B stairwell door was propped open by the facility supervisor for over 15 seconds, which activated the door alarm. The physio assistant #S22 responded to the alarm in a timely manner but was not able to cancel the door alarm because the employee swipe card had not been programmed. Staff member #S22 indicated he/she was not notified of the change in the door alarm system and thought the door alarm had been activated by the wander-guard system.

On level 2 - the B stairwell door alarm was activated and no staff member, carrying pagers, responded in a timely manner. The second level is a dementia unit. Staff member #S10 was in the hallway at the time the alarm was activated but did not respond to the audible alarm. When staff member #S10 was asked to cancel the

alarm, staff member #S10 did not know how to deactivate the door alarm using the swipe card

On level 3 - the B stairwell door alarm was activated and the RN heard the alarm from the enunciator in the nurses' office. The RN did not check it to see which door alarm was ringing but delegated to two staff members to check the other two stairwell doors while he/she checked the B stairwell.. He/she responded in a timely manner and knew how to deactivate the alarm. PSW #S12 was asked to deactivate the door alarm and he/she was not able to cancel the alarm using the swipe card. He/she indicated that he/she had read the memo on how to proceed to deactivate the door alarm but had not mastered the procedure. His/her pager was observed by the inspector and it is to be noted that the pager had been set up to display the "cancelled door alarm" but not to display the stairway door alarm while it was ringing.

On level 4 - the B stairwell door alarm was activated, no staff member responded to the door alarm. Staff member #S14 was in the office and was speaking with staff member #S15. Neither one of them acknowledged the alarm from the nurse enunciator. Staff member #S14 indicated he/she had faxed an order to pharmacy and was distracted when staff member #S15 came in to talk with him/her. Neither staff member responded to the enunciator alarm in a timely manner.

On level 5 - the B stairwell door alarm was activated and no staff member responded. One housekeeper was in the dining room and claimed he/she could not hear the alarm. The inspector went to the dining room and observed that the stairway door alarm sound was faint. The nurses' office door was closed and the alarm from the audio visual enunciator was not audible from the hallway.

The inspector returned to the home the same day at 16:00 to inspect the ground and 1st level doors leading to the unsecured outside areas. The inspector was accompanied by the Manager of Recreation and Leisure. It was noted that the lower level door alarms leading to the outside are connected to the staff's communication system (pagers) on second floor, which is the nearest to the door. The receptionist on duty August 30, 2013 at 16:00 reported to the inspector that he/she is responsible to respond to the door alarms from the ground and first levels between 16:00 and 20:00hrs.

It is to be noted that Inspector #134 was made aware at 11:15 that morning that the

enunciator at the main reception had been unplugged for an undetermined period. The receptionist on duty at the time reported to the inspector that he/she had not heard the alarm ring at all this week and did not realize that it had been unplugged. As such, this indicates that the evening receptionist would not have been alerted if any lower level door alarms had gone off.

On August 30 at 16:15 staff member #S18, working on the second floor did not have a pager on him/her at the time the pub door leading to the unsecured garden was ringing for a prolonged period. When interviewed by the inspector, staff #S18 reported that he/she had left his/her pager in the linen room while he/she went to break and then had forgotten to retrieve it when he/she came back to the unit. The charge nurse on second floor heard a pager go off, which had been left on the work table in the office. This pager was displaying that the pub door alarm had been activated. The charge nurse did not check the pager or inquire why no one was canceling the pub door alarm on the lower level.

On the evening shift of August 30, 2013, the door alarm on 7C was activated at approximately 17:00. Staff members #S19 and #S20, were both in the nursing office and neither one responded to the alarm from the audio visual enunciator in the nursing station. Once they were called to the stairway door by Inspector #134, staff members #S19 and #20, did not know how to cancel the door alarms at the point of activation using their swipe cards.

Although the doors leading to stairways and unsecured outside areas are equipped with newly installed audible door alarms that are connected to an audio enunciator on the 3rd, 4th, 5th 6th and 7th residents' care areas and that the ground and first level door alarms are connected to the resident-staff communication and response system (pagers), the inspector found that there remains a number of issues to be addressed.

As such, the home is not a safe and secured environment for its residents when the level of sound from the audio enunciator is not audible to staff in the nursing offices or on the units; when staff do not respond promptly to the alarmed doors; when staff with pagers do not carry them or inquire why certain door alarms are ringing for a prolonged period of time; and when staff do not know how to cancel the door alarm at the point of activation using their swipe cards. Furthermore, the inconsistent approach in how the licensee is utilizing pagers whereby the staff's pagers, on the second floor, are set up to display which door alarm is ringing, while on other floors the staff pagers

enunciator at the main reception had been unplugged for an undetermined period. Th

Additional Required Actions:

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

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 9. (1)	CO #001	2013_230134_0005	134

Issued on this 6th day of September, 2013

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

Colette Cassidy, LTCH Inspector #134

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) :	COLETTE ASSELIN (134)
Inspection No. / No de l'inspection :	2013_230134_0007
Log No. / Registre no:	O-000641-13
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Sep 6, 2013
Licensee / Titulaire de permis :	CITY OF OTTAWA Long Term Care Branch, 275 Perrier Avenue, OTTAWA, ON, K1L-5C6
LTC Home / Foyer de SLD :	GARRY J. ARMSTRONG HOME 200 ISLAND LODGE ROAD, OTTAWA, ON, K1N-5M2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MARLYNNE FERGUSON

To CITY OF OTTAWA, 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 :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with s. 5 of the LTCHA, to ensure that the level of sound from the audio enunciators are calibrated so that they are audible to staff in the nursing office and on the unit, that staff carry their pagers at all times, that all staff who work on different units (i.e PTA and physio) have programmed swipe cards to cancel the door alarms at the point of activation and that all staff be individually trained on how to cancel the audible door alarm at the point of activation.

This plan must be submitted in writing to Inspector, Colette Asselin, at 347 Preston Street, 4th floor, Ottawa, ON K1S 3J4 or by fax at 613-569-9670 on or before September 20, 2013.
Full compliance with this order shall be October 4, 2013.

Grounds / Motifs :

1. 1. The licensees failed to comply with the LTCHA, 2007, c.8, s. 5, in that the home is not a safe and secured environment for its residents since the recently installed door alarms on doors leading to stairwells or unsecured areas outside the home are not responded too, in a timely manner.

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to deactivate the door alarm but had not mastered the procedure. His/her pager was observed by the inspector and it is to be noted that the pager had been set up to display the "cancelled door alarm" but not to display the stairway door alarm while it was ringing.

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staff #S18 reported that he/she had left his/her pager in the linen room while he/she went to break and then had forgotten to retrieve it when he/she came back to the unit. The charge nurse on second floor heard a pager go off, which had been left on the work table in the office. This pager was displaying that the pub door alarm had been activated. The charge nurse did not check the pager or inquire why no one was canceling the pub door alarm on the lower level.

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The risk level associated with not responding to the alarmed doors leading to a stairway or outside unsecured area, was deemed a potential risk to residents and provided sufficient grounds to issue this order. (134)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 04, 2013

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.

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

Ministère 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

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 6th day of September, 2013

Signature of Inspector / Signature de l'inspecteur : Colette Asselin

Name of Inspector / Nom de l'inspecteur : COLETTE ASSELIN

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