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 prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jun 01, 2017;	2017_563670_0007 (A2)	007569-17	Resident Quality Inspection

Licensee/Titulaire de permis

Schlegel Villages Inc
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

THE VILLAGE OF ASPEN LAKE
9855 McHugh Street WINDSOR ON N8P 0A6

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

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 prévue le Loi de 2007 les foyers de soins de longue durée

DEBRA CHURCHER (670) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance date has been extended to July 14, 2017 as per discussion with Dana Houle Administrator June 1, 2017.

Issued on this 1 day of June 2017 (A2)

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

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

Ministère de la Santé et des Soins de longue durée

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

DEBRA CHURCHER (670) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): April 18, 20, 21, 24, 25, 26, 27 and 28, 2017.

The following intakes were completed within the RQI:

Log# 031573-16 CIS# 3037-000061-16 related to a missing resident under three hours.

Log# 031717-16 CIS# 3037-000054-16 related to a fall with injury.

Log# 004818-16 CIS# 3037-000010-16 related to a fall with injury.

Log# 034402-16 CIS# 3037-000073-16 related to a fall with injury.

Log# 012185-16 CIS# 3037-000022-16 related to a fall with injury.

Log# 009935-16 CIS# 3037-000016-16 related to a fall with injury.

Log# 031759-16 CIS# 3037-000062-16 related to a fall with injury.

Log# 009673-16 CIS# 3037-000021-16 related to alleged abuse and neglect.

Log# 013059-16 CIS# 3037-000010-16 related to alleged abuse and neglect.

During the course of the inspection, the inspector(s) spoke with forty + Residents, the representative of the Family Council, representative of the

Resident's Council, General Manager, Acting Director of Nursing Care, Maintenance Supervisor, Dietitian, three Registered Practical Nurse RAI Coordinators, two Physio Therapy Assistants, one Dietary Aide, one Assistant Director of Food Services, fourteen Personal Support Workers, thirteen Registered Practical Nurses, one Registered Nurse and one Neighborhood Coordinator.

During the course of this inspection, the inspectors toured all resident home areas, observed dining services, medication rooms, medication administration and medication count, the provision of resident care, recreational activities, resident/staff interactions, infection prevention and control practices and reviewed resident clinical records, posting of required information and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Admission and Discharge

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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

5 WN(s)
4 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. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (5) The licensee shall ensure that the emergency plans address the following components:
1. Plan activation. O. Reg. 79/10, s. 230 (5).
2. Lines of authority. O. Reg. 79/10, s. 230 (5).
3. Communications plan. O. Reg. 79/10, s. 230 (5).
4. Specific staff roles and responsibilities. O. Reg. 79/10, s. 230 (5).

Findings/Faits saillants :

(A2)

1. The licensee has failed to ensure that the emergency plans addressed specific staff roles and responsibilities in relation to the monitoring of the doors during an event in the home.

A critical incident system report for a resident indicated that the resident had a fall during an event in the home when they were able to access a non resident area of the home. This was unwitnessed by staff from the unit where the resident resided.

The General Manager (GM) stated that training and education was provided to all staff in the home following this as the internal investigation concluded that training was required on the functioning of the magnetic locks on the doors during certain events in the home as staff were not aware that the magnetic locks were non functional during the event.

Clinical record review for the resident included an additional occasion, when the resident was again found in a non-resident home area during an event that occurred in the home.

A Registered Practical Nurse (RPN) stated that the doors should be monitored during specific events to ensure that the magnetic locks are not disengaged and that the RPN felt that it should be the registered staff who monitored this or directed another staff member to monitor the doors.

A Personal Support Worker stated that the doors should be monitored certain events to ensure that the magnetic locks were not disengaged and that there was not a set rule on who should do this.

The General Manager stated that the they felt that the monitoring of the magnetic locks on the doors should be monitored by the registered staff on the unit and the registered staff would then delegate to an individual as required. The GM stated that this was not part of the training previously provided to staff. The GM acknowledged that staff did not monitor the doors during a specific home event, on both occasions that the resident was able to get into a non-resident area of the home.

The home's policy was also reviewed and did not include specifically that the magnetic locks on the doors required to be monitored during specific events in the home nor did it identify who should monitor the magnetic lock doors in the roles

and responsibilities of the individual disciplines.

The General Manager acknowledged that the home plan did not include specific staff roles and responsibilities in relation to the monitoring of the doors during specific events in the home and that staff had not monitored the magnetic lock doors on two occasions were a resident was able to access nonresident area of the home.

The severity was determined to be a level three as there was actual harm/risk. The scope of this issue was isolated during this inspection. There was compliance history of one or more unrelated non-compliance in the last three years. [s. 230. (5)]

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 001

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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system that was put in place, was complied with.

The home's Weight Policy, Tab 07-29 provided direction to staff to weigh all residents at a minimum of monthly and to record resident weights in their clinical software record.

The clinical record for a resident stated that the resident was admitted to the home on a specific date and was assessed as being a high nutritional risk.

The clinical record for the resident stated there was no weight recorded for a specific month. Clinical record showed a weight loss of over 3 kilogram's (kg's) over a four month period.

Registered Dietitian (RD) acknowledged that the clinical record for the resident did not include a weight for a specific month, and that a weight loss of 2 kg's or more in a 30 day period would have been flagged within the software program and a referral initiated for a nutritional assessment had the weight been done.

RD also acknowledged that the resident was not assessed until the resident had lost a significant amount of weight.

Two Registered Practical Nurse's (RPN's) told the Inspector that the the resident did not have a weight recorded for a specific month.

The Acting Director of Care (ADOC) told the Inspector that the home's Weight Policy was not followed by nursing personnel with respect to the resident and that dietary interventions may have been relevant had a weight been taken monthly.

The severity was determined to be a level two minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of one or more related non-compliance in the last three years. [s. 8. (1) (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 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, (b) is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
2. The physical device is well maintained. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 2. The physical device is well maintained.

On a specific date the inspector observed a resident sitting in the lounge sliding down in the chair. Upon further observation a restraint was observed to be in place. The restraint was damaged and in poor condition.

A Registered Practical Nurse (RPN) stated that this resident was always in that position and that they saw no issues with the restraint. The Inspector requested that they contact the Acting Director of Care (ADOC) or General Manager (GM) to come to the unit immediately.

The GM and an Exercise Therapist both attended the unit. Both the GM and the Exercise Therapist acknowledged that the restraint was damaged and was potentially unsafe. The GM and the Exercise Therapist informed the inspector that they would be immediately removing the resident from the chair and the restraint, would be placing the resident in bed and the vendor would be contacted to replace the restraint that evening.

The licensee failed to ensure that the physical device was well maintained for a resident.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during this inspection. There was a compliance history of one or more related non-compliance in the last three years. [s. 110. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: The physical device is well maintained, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the

resident and the pharmacy service provider.

Registered Practical Nurse's (RPN's) stated during interviews that if a medication incident was identified, that the expectation would be to complete the home's "Medication Incident Report" form, to include an explanation of the incident, what was done to monitor the resident, notification of the physician, the resident or SDM, the Director of Care and the pharmacy. An RPN further stated that if the physician provided instruction that this should also be included on the "Medication Incident Report" form as well as the actions taken to assess the resident for any adverse effects. The RPN's each stated that if the medication incident did not affect the resident that it would not be necessary to inform the resident or SDM.

Medication Incident Reports were reviewed for a three month period, and there were forty one documented incidents. Of those incidents, four were noted to be "near misses that did not reach the resident and the resident or SDM were not notified. Fourteen were noted to have reached the resident in some manner. Of those fourteen incidents, there were four incidents where no documentation was available to support that the physician had been notified of the incident, and seven incidents that did not have documentation to support that the resident or the SDM had been notified and twenty three incidents did not include documentation of the immediate actions taken to assess the resident. All incidents indicated that the pharmacy had been notified of the incidents.

Two RPN's were interviewed regarding specific medication incidents involving residents. The RPN's were both noted to have been directly involved in these medication incidents, and both stated that because the incident directly involved the resident that the SDM should have been notified of the incidents. Neither were able to recall if the SDM's had been notified. They both stated that the physician had been notified. They acknowledged that the immediate actions taken to assess the resident as a result of the incident had not been documented.

The two SDM's of two resident's were contacted by the inspector as documentation could not be located to indicate notification of the medication incidents involving these residents. Both confirmed that they had not been contacted regarding the noted medication incidents.
The Acting Director of Care (ADOC) stated during an interview that it would be expected that a "Near Miss incident, described as an incident that did not reach the resident and did not cause harm, would not require the SDM to be notified. The ADOC stated that a medication incident that reached the resident, described as a

wrong dose, a missed dose, the wrong medication as examples, would require the SDM to be notified. The ADOC stated that this notification should be documented on the "Medication Incident Report" form and also in the clinical record for the resident. The ADOC stated that if this documentation was not present then the notification likely did not occur. The ADOC also stated that the immediate assessment of the resident for any adverse effects should be documented on the "Medication Incident Report" form as well as in the clinical record. [s. 135. (1)]

2. The licensee has failed to ensure that all medication incidents are documented, reviewed and analyzed.

The home's policy titled "Medication Incidents" last reviewed January 17, 2017 stated: "The Medication Incident Reports will be analyzed by nursing administration, the Pharmacy Manager, and/or consultant pharmacist to determine whether pharmacy and/or nursing procedures require modification".

The Acting Director of Care (ADOC) stated that monthly, the ADOC reviewed and created a summary of the medication incidents for the month and forwarded the document to the General Manager (GM) for review, and that the GM addressed any issues or concerns of the information.

The General Manager (GM) stated that the GM did receive a monthly document regarding medication incidents from the ADOC but that it was only the number of medication incidents that were recorded, and if there were any adverse drug reactions, but there was no further analysis of the medication incidents completed. [s. 135. (2)]

3. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, any changes and improvements identified in the review were implemented, and a written record was kept of everything provided for in clause (a) and (b).

The most recent Home Advisory Committee (HAC) Meeting, was attended by the home's interdisciplinary team, including the Pharmacist consultant. The HAC meeting minutes documented nine medication incidents during a previous three month period. The details provided for in the report included the origin of the errors and that no Adverse Drug Reactions had been reported. For the three errors noted

as origin from Pharmacy, there was documentation to support that interventions were completed to reduce and prevent medications incidents and adverse drugs reactions, but did not include identification of changes and improvements or of their implementation. The six errors noted as origin of Nursing did not include documentation to support that interventions were completed to reduce and prevent medications incidents and adverse drugs reactions, the identification of any changes and improvements, or of their implementation.

The General Manager (GM) acknowledged that at the HAC meeting, nine medication incidents were documented and were not analyzed. The GM acknowledged that a quarterly review was not undertaken of all medication incidents and adverse drug reactions during a previous three month period and changes and improvements were not identified in the review and a written record was not kept of everything.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. There was a compliance history of one or more unrelated non-compliance in the last three years. [s. 135. (3)]

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; every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider;
to ensure that all medication incidents and adverse drug reactions are reviewed and analyzed
and corrective action is taken as necessary;
to ensure that a quarterly review is undertaken of all medication incidents and adverse
reactions that have occurred in the home since the time of the last review and a written
record is kept, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 224. Information for residents, etc.

Specifically failed to comply with the following:

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
3. The obligation of the resident to pay accommodation charges during a medical, psychiatric, vacation or casual absence as set out in section 258 of this Regulation. O. Reg. 79/10, s. 224 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the admission package includes the resident's obligation to pay accommodation charges during a medical, psychiatric, vacation or casual absence from the home.

General Manager (GM) returned the completed LTCH Licensee Confirmation Checklist Admission Process to the inspection team. The home provided a negative answer to question 2.j.v. “Does the admission package of information include the following: Resident’s obligation to pay for the basic accommodation charge, including during approved leave of absences from the home (e.g. during a medical, psychiatric, vacation and casual absences;"

GM stated that they had reviewed the home’s admission contract and there was no reference to the resident’s obligation to pay for the basic accommodation charge, including during approved leaves of absence from the home (e.g. during a medical, psychiatric, vacation and casual absences. GM #104 shared that the home was in the process of revising the admission contract and reference to the resident’s obligations in relation to paying the basic accommodation charge would be included. A draft copy was supplied to the inspector.

The severity was determined to be a level one as there was minimum risk. The scope of this issue was widespread during this inspection. There was a compliance history of one or more unrelated non-compliance in the last three years. [s. 224. (1) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the package of information provided for in section 78 of the Act includes information about the following: 3. The obligation of the resident to pay accommodation charges during a medical, psychiatric, vacation or casual absence as set out in section 258 of this Regulation, to be implemented voluntarily.

Issued on this 1 day of June 2017 (A2)

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : DEBRA CHURCHER (670) - (A2)

Inspection No. / No de l'inspection : 2017_563670_0007 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 007569-17 (A2)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Jun 01, 2017;(A2)

Licensee / Titulaire de permis : Schlegel Villages Inc
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

LTC Home / Foyer de SLD : THE VILLAGE OF ASPEN LAKE
9855 McHugh Street, WINDSOR, ON, N8P-0A6

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Dana Houle

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

To Schlegel Villages 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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 230. (5) The licensee shall ensure that the emergency plans address the following components:

1. Plan activation.
2. Lines of authority.
3. Communications plan.
4. Specific staff roles and responsibilities. O. Reg. 79/10, s. 230 (5).

Order / Ordre :

1) The Licensee shall ensure that there is an emergency plan in place that addresses specific staff roles and responsibilities when the plan is activated.
2) The Licensee shall ensure that staff are provided direction and education related to their specific roles and responsibilities when the emergency plan is activated.

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure that the emergency plans addressed specific staff roles and responsibilities in relation to the monitoring of the doors to stairwells during a fire alarm event.

Critical incident system 3037-000062-16 for resident #064 indicated that the resident had sustained a fractured rib from a fall on October 29, 2016 where the resident fell down the staircase in a wheelchair with an intact tabletop during a fire alarm. This was unwitnessed by staff from the unit where the resident resided. It was staff on another floor who discovered the fall when the resident walked out of the stairwell on another floor following the fall.

The General Manager (GM) #104 stated that training and education was provided to

all staff in the home following this as the internal investigation concluded that training was required on the functioning of the magnetic locks on the stairwell doors during a fire alarm event as staff were not aware that the magnetic locks were non functional during the evacuation stage of a fire alarm.

Clinical record review for resident #064 included an additional event dated April 18, 2017, when the resident was again found in the stairwell during a fire alarm event.

Registered Practical Nurse (RPN) #107 stated that the stairwell doors should be monitored during a fire alarm event to ensure that the magnetic locks are not disengaged and that the RPN felt that it should be the registered staff who monitored this or directed another staff member to monitor the stairwell.

Personal Support Worker #139 stated that the stairwell doors should be monitored during a fire alarm event to ensure that the magnetic locks were not disengaged and that there was not a set rule on who should do this.

The General Manager #104 stated that the GM felt that the monitoring of the magnetic locks on the stairwell doors should be monitored by the registered staff on the unit and the registered staff would then delegate to an individual as required. The GM #104 stated that this was not part of the training previously provided to staff.

The home's policy was also reviewed and did not include specifically that the magnetic locks on the stairwell doors required to be monitored during a fire alarm event nor did it identify who should monitor the magnetic lock doors of the stairwells in the roles and responsibilities of the individual disciplines.

The General Manager acknowledged that the home plan did not include specific staff roles and responsibilities in relation to the monitoring of the doors during specific events in the home and that staff had not monitored the magnetic lock doors on two occasions were a resident was able to access nonresident area of the home.

The severity was determined to be a level three as there was actual harm/risk. The scope of this issue was isolated during this inspection. There was compliance history of one or more unrelated non-compliance in the last three years. [s. 230. (5)] (537)

(537)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le :

Jul 14, 2017(A2)

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
Long-Term Care Inspections 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

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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 1 day of June 2017 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DEBRA CHURCHER - (A2)

Service Area Office /
Bureau régional de services : London