



**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

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) :	JESSICA LAPENSEE (133)
Inspection No. / No de l'inspection :	2012_054133_0018
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Apr 26, 27, May 1, 2, 3, 2012
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 55 Standish Court, 8th Floor, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	THUNDER BAY INTERIM LONG-TERM CARE CENTRE 445 SOUTH JAMES STREET, THUNDER BAY, ON, P7E-2V6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JULIANA JASON <u>DIANE MORIN</u>

To Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:



**Ministry of Health and
Long-Term Care**

Order(s) of the Inspector
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section 154 of the *Long-Term Care
Homes Act, 2007*, S.O. 2007, c.8

**Ministère de la Santé et
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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) (a)
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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.

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. (1).

Order / Ordre :

The licensee shall ensure resident safety by verifying that the alarms currently installed on exit doors are functional at all times and that the locking devices currently installed on exit doors and doors leading to stairways are functional at all times. The licensee will ensure that no residents at risk of elopement or with known exit seeking behaviors are able to exit the home due to non functioning door locks and alarms.

Grounds / Motifs :



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1. The licensee failed to ensure that the front door, which is equipped with a magnetic locking device, was kept locked on a day in February 2012.

As reported to the MOHLTC in a Critical Incident Report, resident #1 eloped through the front door in the early morning on a day in February 2012. The Acting Administrator in place at the time of the inspection confirmed with the inspector that she found resident #1 outside in the drive way, past the parking lot and heading towards James Street when she arrived to work on this day in February 2012, at approximately 6:30am. The resident, who is visually impaired, was found dressed in her/his pyjamas and slippers. The Environmental Services Manager explained to the inspector that following the resident's elopement, he determined that the magnetic lock system on the door had been disabled and therefore resident #1 was able to simply push the front door open. [O.Reg. 79/10, s.9(1)1.i] (133)

2. The licensee failed to ensure that the resident accessible exit door at the Amethyst Harbor lounge was equipped with a functional alarm on April 26th 2012.

In the afternoon, on April 26th 2012, the inspector discovered that the alarm on the exit door in the Amethyst Harbor Lounge was not functional. A staff person in the area at the time of this discovery informed the inspector that resident #2 had eloped through this door on an earlier day in April 2012 and that the alarm was functional at that time which allowed staff to respond quickly and find the resident just outside the exit door. [O.Reg. 79/10, s.9(1)1.iii] (133)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : May 04, 2012



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REVIEW/APEAL 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
55 St. Clair Avenue 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 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
55 St. Clair 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.



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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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
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 3rd day of May, 2012

**Signature of Inspector /
Signature de l'inspecteur :**

**Name of Inspector /
Nom de l'inspecteur :**

JESSICA LAPENSEE

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

Sudbury Service Area Office



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

**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**

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Apr 26, 27, May 1, 2, 3, 2012	2012_054133_0018	Critical Incident

Licensee/Titulaire de permis

Revera Long Term Care Inc.
55 Standish Court, 8th Floor, MISSISSAUGA, ON, L5R-4B2

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

THUNDER BAY INTERIM LONG-TERM CARE CENTRE
445 SOUTH JAMES STREET, THUNDER BAY, ON, P7E-2V6

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, the Director of Care, the Regional Manager of Clinical Services, the Environmental Services Manager, Registered Nursing staff and Personal Support Workers.

During the course of the inspection, the inspector(s) toured throughout the home and assessed door security at resident accessible doors that lead to stairways and to the outside of the home. The inspector also reviewed components of two residents' health care record.

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



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Legend	Legende
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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 subsections:

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.

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. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident accessible exit door at the Amethyst Harbor lounge was equipped with a functional alarm on April 26th 2012.

In the afternoon, on April 26th 2012, the inspector discovered that the alarm on the exit door in the Amethyst Harbor lounge was not functional. A staff person in the area at the time of this discovery informed the inspector that resident #2 had eloped through this door on an earlier day in April 2012 and that the alarm was functional at that time which allowed staff to respond quickly and find the resident just outside the exit door. [O.Reg. 79/10, s.9(1)1.iii]

2. The licensee has failed to ensure that all resident accessible exit doors and doors leading to stairways are equipped with an audible door alarm as required. With regards to exit doors, this is in specific reference to the front door, the nurse station exit door and the main dining room exit door. With regards to doors leading to stairways, this is in specific reference to the door at the nurse station, the door at the main dining room and the two corresponding stairway doors in the basement. The basement is accessible to residents via the elevator. [O.Reg. 79/10, s.9.(1)1.iii]

3. The licensee failed to ensure that the front door, which is equipped with a magnetic locking device, was kept locked on a day in February 2012.

As reported to the MOHLTC in a Critical Incident Report, resident #1 eloped through the front door in the early morning on a day in February 2012. The acting Administrator in place at the time of the inspection confirmed with the inspector that she found resident #1 outside in the drive way, past the parking lot and heading towards James Street when she arrived to work on this day in February 2012, at approximately 6:30am. The resident, who is visually impaired, was found dressed in her/his pyjamas and slippers. The Environmental Services Manager explained to the inspector that following the resident's elopement, he determined that the magnetic lock system on the door had been disabled and therefore resident #1 was able to simply push the front door open. [O.Reg. 79/10, s.9(1)1.i]

4. The licensee has failed to ensure that all resident accessible doors leading to stairways and to the outside of the home are kept locked. This is in specific reference to two stairwell doors in the basement, which is accessible to residents via the elevator and four exit doors around the perimeter of the building (in the Administration wing, at the Mount McKay Way Lounge, at the Amethyst Harbor lounge and at the Director of Care's office) [O.Reg. 79/10, s.9(1)1.i]

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. 10. Elevators

Specifically failed to comply with the following subsections:

s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the elevator is equipped to restrict resident access to the basement which does not contain any areas used by residents. The elevator button is obscured from view with a raised metal plate. In the evening, on April 26th, the inspector took the elevator to the basement and found the door leading into the laundry room open. The inspector also noted the doors into the male and female staff locker rooms unlocked as well as two unlocked doors that are not alarmed which lead to stairways.

**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:**



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CORRECTED 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 r. 33.	CO #001	2012_053122_0001	133

Issued on this 4th day of May, 2012

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

Jessica Lapensee