Ministry of Health and Long-Term Care

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Ottawa Service Area Office

347 Preston St., 4th Floor
Ottawa ON K1S 3J4
Telephone: 613-569-5602
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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
Bureau régional de services de Ottawa

347, rue Preston, 4iém étage
Ottawa ON K1S 3J4
Téléphone: 613-569-5602
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November 30, 2011

Mr. Bob Knight
Administrator
Victoria Manor Home for the Aged
220 Angeline Street South
Lindsay ON K9V 4R2

Dear Mr. Knight:

Please find enclosed the ***Revised orders - Public Copy*** for an inspection conducted on February 17, 2011 under the *Long-Term Care Homes Act, 2007* (LTCHA) for the purpose of ensuring compliance with requirements under the LTCHA.

This inspection report must be posted in the home, in a conspicuous and easily accessible location in accordance with the LTCHA, 2007, S.O. 2007, c.8, s.79 (1) and (2).

A copy of the ***Revised orders - Public Copy*** must be made available without charge upon request. The report will also be on file with the Ottawa Service Area Office, Performance Improvement and Compliance Branch.

Sincerely

Wendy Berry
LTC Home Inspector – Environmental Health

c President, Resident's Council
President, Family Council

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

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

Order(s) of the Inspector (Ammended)

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

	Licensee Copy/Copie du Titulaire	X Public Copy/Copie Public	
Name of Inspector:	Wendy Berry	**Inspector ID #**	102
Log #:	O-000346		
Inspection Report #:	2011_102_9589_17Feb141557		
Type of Inspection:	Critical Incident		
Date of Inspection:	February 17, 2011		
Licensee:	The Corporation of the City of Kawartha Lakes 26 Francis Street, Lindsay, Ontario K9V 5R8 Fax # 705 324 5417		
LTC Home:	Victoria Manor Home For The Aged 220 Angeline Street South, Lindsay, Ontario K9V 4R2 Fax # 705 324 8607		
Name of Administrator:	Hildy Nickel		

To The Corporation of the City of Kawartha Lakes, you are hereby required to comply with the following orders by the dates set out below:

Order #:	002	**Order Type:**	. Compliance Order, Section 153 (1)(a)
Pursuant to: O. Reg. 79/10, s. 9. 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 must be, i. kept closed and locked			
Order: All doors leading to stairways and to the outside of the home are to be kept closed and locked.			
Grounds: On February 17, 2011, 13 doors leading to stairways and to the outside of the home that were checked and located within the 1st floor MacMillan resident home area, the 1st floor central core and lobby area, and the basement, were closed but not locked: 1. 5 doors leading to stairways were not locked and are accessible to residents of the Long Term			

Care Home: 1st floor door, adjacent to the elevators, leading from the lobby into the stairway to the 2nd floor; the 1st floor door, located between MacMillan wing resident rooms labelled "W107" and "W108", leading from the corridor into a stairway; the 1st floor door, located between MacMillan wing resident rooms labelled "W119 and W120" leading from the corridor into a stairway; the basement door, located between rooms labelled "sprinkler room" and "supply room", leading from the corridor to a stairway; the basement door, adjacent to door labelled "N002 Sump", leading from the corridor to an exterior stairway.

2. 9 doors leading to the outside of the home were not locked and are accessible to residents of the Long Term Care Home: 1st floor main entrance doors, facing towards Angeline Street, that leads from the lobby to the outside (doors are on interior and exterior motion activated sensors that open the doors); 1st floor rear entrance door, facing rear parking lot, that leads from the lobby to the outside; 1st floor door, in the vicinity of the chapel, that leads from 1st floor corridor to the outside near the generator; 1st floor door, in the vicinity of the chapel, leading from the stairway to the outside of the home by the generator; 1st floor exit door, adjacent to office "N136", leading from the corridor to the outside rear raised walkway facing the parking lot; 1st floor exit door leading from the stairway, located between resident rooms "W107" and "W108", leading to the outside ; 1st floor door leading from the stairway, between resident rooms "W119" and "W120", to the outside; basement door adjacent to room "N055 kitchen receiving room" that leads to the outside raised loading dock at the rear of the home; the basement door, adjacent to door labelled "N002 Sump", leading from the corridor to an outside stairway.

3. On February 11, 2011, a female resident of the Long Term Care Home was identified on a Critical Incident Report # M589-000006-11, as a missing resident for less than 3 hours. The resident was found sitting on a snow bank, one block north of the home. It was reported that the resident has a diagnosis of dementia. The resident did not have her walker with her. It was also reported that "it was cold and the sidewalks were icy" at the time of elopement.

This order must be complied with by:	September 01, 2011/**AMMENDED DATE: February 28, 2012**

Order #:	003	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: O. Reg. 79/10, s. 9. 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 must be,
   ii. equipped with a door access control system that is kept on at all times

Order: All doors leading to stairways and the outside of the home are to be equipped with a door access control system that is kept on at all times.

Grounds: On February 17, 2011, 13 doors leading to stairways and to the outside of the home that were checked and located within the 1st floor MacMillan resident home area, the 1st floor central core and lobby area, and the basement, were not equipped with a door access control system that is kept on at all times:

1. 5 doors leading to stairways: 1st floor door, adjacent to the elevators, leading from the lobby into the stairway to the 2nd floor; the 1st floor door, located between MacMillan wing resident rooms labelled "W107" and "W108", leading from the corridor into a stairway; the 1st floor door, located between MacMillan wing resident rooms labelled "W119 and W120" leading from the corridor into a stairway; the basement door, located between rooms labelled "sprinkler room" and "supply room", leading from the corridor to a stairway; the basement door, adjacent to door labelled "N002 Sump", leading from the corridor to an exterior stairway.

2. 9 doors leading to the outside of the home: 1st floor main entrance doors, facing towards Angeline Street, that leads from the lobby to the outside (doors are on interior and exterior motion activated sensors that open the doors); 1st floor rear entrance door, facing rear parking lot, that leads from the lobby to the outside; 1st floor door, in the vicinity of the chapel, that leads from 1st floor corridor to the outside near the generator; 1st floor door, in the vicinity of the chapel, leading from the stairway to the outside of the home by the generator; 1st floor exit door, adjacent to office "N136", leading from the corridor to the outside rear raised walkway facing the parking lot; 1st floor exit door leading from the stairway, located between resident rooms "W107" and "W108", leading to the outside ; 1st floor door leading from the stairway, between resident rooms "W119" and "W120", to the outside; basement door adjacent to room "N055 kitchen receiving room" that leads to the outside raised loading dock at the rear of the home; the basement door, adjacent to door labelled "N002 Sump", leading from the corridor to an outside stairway.

3. On February 11, 2011, a female resident of the Long Term Care Home was identified on a Critical Incident Report # M589-000006-11, as a missing resident for less than 3 hours. The resident was found sitting on a snow bank, one block north of the home. It was reported that the resident has a diagnosis of dementia. The resident did not have her walker with her. It was also reported that "it was cold and the sidewalks were icy" at the time of elopement.

This order must be complied with by:	September 01, 2011/ **AMMENDED DATE: February 28, 2012**

Order #:	004	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: O. Reg. 79/10, s. 9. 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 must be,
   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.

Order: All doors leading to stairways and the outside of the home are to be equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and the alarm is to be

a. connected to the resident-staff communication and response system, or
b. 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.

Grounds: On February 17, 2011, 13 doors leading to stairways and to the outside of the home that were checked and located within the 1st floor MacMillan resident home area, the 1st floor central core and lobby area, and the basement, were not equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and that is connected to the resident-staff communication and response system or to an audio visual enunciator that is connected to the nurses' station nearest to the door with a manual reset switch at each door:

1. 5 doors leading to stairways: 1st floor door, adjacent to the elevators, leading from the lobby into the stairway to the 2nd floor; the 1st floor door, located between MacMillan wing resident rooms labelled "W107" and "W108", leading from the corridor into a stairway; the 1st floor door, located between MacMillan wing resident rooms labelled "W119 and W120" leading from the corridor into a stairway; the basement door, located between rooms labelled "sprinkler room" and "supply room", leading from the corridor to a stairway; the basement door, adjacent to door labelled "N002 Sump", leading from the corridor to an exterior stairway.

2. 9 doors leading to the outside of the home: 1st floor main entrance doors, facing towards Angeline Street, that leads from the lobby to the outside (doors are on interior and exterior motion activated sensors that open the doors); 1st floor rear entrance door, facing rear parking lot, that leads from the lobby to the outside; 1st floor door, in the vicinity of the chapel, that leads from 1st floor corridor to the outside near the generator; 1st floor door, in the vicinity of the chapel, leading from the stairway to the outside of the home by the generator; 1st floor exit door, adjacent to office "N136", leading from the corridor to the outside rear raised walkway facing the parking lot; 1st floor exit door leading from the stairway, located between resident rooms "W107" and "W108", leading to the outside ; 1st floor door leading from the stairway, between resident rooms "W119" and "W120", to the outside; basement door adjacent to room "N055 kitchen receiving room" that leads to the outside raised loading dock at the rear of the home; the basement door, adjacent to door labelled "N002 Sump", leading from the corridor to an outside stairway.

3. On February 11, 2011, a female resident of the Long Term Care Home was identified on a Critical Incident Report # M589-000006-11, as a missing resident for less than 3 hours. The resident was found sitting on a snow bank, one block north of the home. It was reported that the resident has a diagnosis of dementia. The resident did not have her walker with her. It was also reported that "it was cold and the sidewalks were icy" at the time of elopement.

Noted that some of the doors were connected to an audio visual enunciator located within the MacMillan nursing station. Staff present in the nursing station did not know how to operate the system.

This order must be complied with by:	September 01, 2011 **AMMENDED DATE: February 28, 2012**

Ontario

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

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

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:

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 15th day of August, 2011. Order amended November 18, 2011	
Signature of Inspector:	
Name of Inspector:	Wendy Berry
Service Area Office:	Ottawa
