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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 15, 2016	2016_539120_0067	030881-16	Critical Incident System

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

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

BANWELL GARDENS
3000 BANWELL ROAD P. O. BOX 3246 TECUMSEH ON N8N 2M4

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 26 & 27, 2016

Critical Incident #2263-000049-16 was submitted to the Ministry of Health and Long Term Care on September 30, 2016 related to a major flood.

During the course of the inspection, the inspector(s) spoke with the Administrator, Environmental Services Supervisor and residents.

During the course of the inspection, the inspector toured the home, reviewed emergency plans and post flood operational plans for remediation.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

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

- **2 WN(s)**
- **0 VPC(s)**
- **0 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. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the resident-staff communication and response system was available at each shower location used by residents.

Two shower stalls were located within the bathing room located in the corridor identified as "600". An activation station was not made available within the vicinity of the two shower stalls.
[s. 17. (1) (d)]

2. The licensee did not ensure that the resident-staff communication and response system was available in every area accessible by residents.

Activation stations were not equipped in the home's hair salon, main foyer sitting area (with television), outdoor courtyard and the Rose dining room. The activation station located in the physiotherapy room was missing a component and could not be activated.
[s. 17. (1) (e)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (4) The licensee shall ensure that the emergency plans provide for the following:
1. Dealing with,
i. fires,
ii. community disasters,
iii. violent outbursts,
iv. bomb threats,
v. medical emergencies,
vi. chemical spills,
vii. situations involving a missing resident, and
viii. loss of one or more essential services. O. Reg. 79/10, s. 230 (4).

Findings/Faits saillants :

1. The licensee did not ensure that the emergency plans provided for dealing with community disasters, specifically flooding.

On September 29, 2016, the community of Tecumseh and Windsor received a heavy amount of rainfall in a short period of time. At approximately 7:45 a.m., the home was affected after rain water accumulated within the enclosed courtyard and on one side of the building facing a major road. As the building site was situated approximately seven feet below the level of the road, when the roadside ditch filled with rain water and over flowed it's banks, the rain water drained towards one side of the home. The sewage system was also affected, causing black water to back up into the building through toilets and floor drains. Three separate sump pumps situated in the basement of one area of the building were not capable of removing the influx of water that entered the building. As a result, numerous resident rooms, washrooms, several shower rooms and the basement were flooded with over two inches of rain water and in some areas, mixed with both rain water and black water.

The administrator and environmental services supervisor were quick in their response to contact appropriate contractors and agencies to assist in managing the flood. The water was quickly removed and wall cavities dried and residents were able to remain in the building and return to their rooms by the end of the day.

Most of the actions taken and individuals involved were not identified in any written emergency plans. The emergency plan that was provided for review was titled "code orange - external disaster". The plan provided some guidance for the administrator in setting up a command centre and initiating a change in operations which was general in nature. It did not include any information related to flooding. If it were not for the administrator who had experience in dealing with a major flood from a previous incident that occurred several years prior, this particular flood may not have been managed as successfully or quickly. None of the staff in the home had access to a written emergency plan related to flooding. [s. 230. (4) 1.]

Issued on this 21st day of November, 2016

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

Original report signed by the inspector.