Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: February 22, 2023
Inspection Number: 2022-1149-0002
Inspection Type: Complaint CIS
Licensee: Blackadar Continuing Care Centre Inc.
Long Term Care Home and City: Blackadar Continuing Care Centre, Dundas

Lead Inspector	**Inspector Digital Signature**
Kwesi Douglas (736409)	Kwesi J Douglas Digitally signed by Kwesi J Douglas Date: 2023.02.22 14:05:36 -05'00'

Additional Inspector(s)
Bernadette Susnik (120)

INSPECTION SUMMARY

Offsite inspections were conducted December 29, 30, 2022 and January 3, 4, 5, 12, 13, 14,16, 17 and 18, 2023. Onsite Inspections were conducted January 6, 10 and 11, 2023.

The following intake(s) were inspected:

- Intake: #00016938 - Environmental Hazard - Failure/breakdown of major equipment - Generator.
- Intake: #00001242 - Complaint - Concerns regarding housekeeping, pests, mold
- Intake: #00005059 - Complaint - Concerns regarding power outage.
- Intake: #00003765 - Complaint - Concerns re emergency plans.

The following **Inspection Protocols** were used during this inspection:

Safe and Secure Home
Housekeeping, Laundry, and Maintenance Services

INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records, and conducted interviews, as applicable. There were *findings of non-compliance.*

WRITTEN NOTIFICATION: Specific duties re: cleanliness & repair

NC #1 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (a)

The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

Housekeeping concerns related to the resident rooms, dining rooms and air conditioners not being cleaned were initially brought to the attention of the Ministry of Long-Term Care by a complainant.

Rational and Summary

Inspectors observed that tubs located in the tub/shower rooms on the second and third floors did not appear as if they were cleaned after use, as there was a pink residue on the bottom of each tub that could be wiped off. During follow up observations it was noted that the tub was not cleaned.

The inspector observed food preparation, dishwashing and storage areas in the kitchen were not clean. The floors and walls in the dishwashing area were observed with dust and dirt and possible mold. The walls in the dishwashing areas and under the sink and machine areas were observed with dirt and with black mold like substances. Areas behind cooking equipment had a build-up of debris.

When inspecting the dining room on the main floor, windowsills were observed with dust and dirt and the air conditioner on the wall was observed with a black like substance which resembled mold. According to the Environmental and Dietary Manager, maintenance staff were responsible for cleaning the interior of the air conditioners. There were resident rooms observed with a build-up of dust behind night tables and

beds on the third floor. Staff stated that rooms were cleaned once per day and that high touch surfaces received twice per day cleaning when in an outbreak. Staff stated that one resident room was to be deep cleaned each day, but due to time limitations, the task could not always be completed. A resident room's air conditioner was observed with mold.

The Environmental and Dietary Manager stated that the dining rooms were cleaned by both dietary staff and housekeeping staff. Housekeeping staff focused on the floors and dietary staff cleaned the tabletop surfaces. Dietary staff were responsible for cleaning the kitchen. Cleaning schedules for the housekeeping staff required that resident rooms were to be cleaned once per day.

Sources: Interviews (Dietary and Environmental Manager, Housekeeping Staff), Record Review (cleaning schedule) and Observations.

[736409]

WRITTEN NOTIFICATION: Maintenance Services

NC #2 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)

The licensee has failed to ensure there are schedules and procedures were in place for routine, preventative, and remedial maintenance.

Rationale and Summary

According to O. Reg. 246/22, s. 11. (1)(b), where the Regulation requires the licensee to

have, institute, or otherwise put in place any procedure, the licensee is required to ensure that the procedure is complied with.

O. Reg. 246/22, s. 96. (2) (b) requires the licensee to ensure that schedules and procedures are in place for routine, preventative and remedial maintenance.

The licensee failed to ensure that schedules and procedures were in place, specifically for portable air conditioning units, walls, floors and doors of resident rooms and washrooms. The maintenance procedure included audit checklists for all of these areas. However, audits had not been conducted in 2022 of resident rooms and washrooms. The last audit that was completed was in June 2021. The maintenance person was not fully aware of the requirement to complete room audits and had just started in the position three months prior.

The following interior areas of the building were noted to be in poor repair during the inspection:

- The windowsills in many resident bedrooms were not smooth and tight-fitting but had exposed metal and deteriorated and loose material. Both the Administrator and maintenance staff were unaware.
- Many of the bi-fold closet doors were missing completely (privacy curtains provided instead), and those that were provided, were off track (due to missing springs) or could not stay closed and the surfaces were heavily scratched. Vinyl baseboards on walls next to the closets were loose and not adhered to the walls or were ripped.
- Many of the resident ensuite washroom doors were heavily scuffed, scrapped, peeling of paint or damaged.
- Drywall repairs were noted in some resident washrooms or bedrooms but were not painted. Some walls had peeling paint or wallpaper or were heavily scuffed, Wall damage noted around air conditioner in a resident’s room.
- Light pulls missing for overbed light fixtures in resident’s room,
- PVC flooring tile lifting, cracked or had corners missing in resident rooms, soiled utility rooms, and tiles missing in laundry room.
- One washing machine was leaking in the laundry area, apparently for several years.
- Men's public bathroom door on the first-floor could not close properly and was getting stuck on the door frame.

- Wall tiles were missing in the third-floor dining room in the steam table area near the fridge.
- The ceiling in the second-floor tub/shower room was discoloured, a sign of past water damage. Based on an engineering company assessment dated August 11, 2022, the source of the water was from the third-floor shower area, which had leaked down to the second-floor tub room and elevator room via cracks in the flooring material. The Administrator and owner of the home corresponded about the result of the assessment on November 24, 2022, with action towards a resolution. However, no repairs or contract with a repair company has been established to date.

Sources: Observations; Interview (maintenance staff), Record Review (maintenance procedures, schedules and audits).

[120]

WRITTEN NOTIFICATION: Emergency Plans

NC #3 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (4) 3

The licensee has failed to ensure that resources, supplies and equipment vital for the emergency response being set aside were readily available at the home.

Rational and Summary

During the inspection, staff reported that there was insufficient alternative lighting options (flashlights, lamps) during the power outage on December 23, 2022, as the generator was not in operation between approximately 5 p.m. and 12 a.m.

Residents did not have access to alternative lighting and there was insufficient flashlights and lamps for those who needed them throughout the home. Staff stated that the lighting was inadequate.

There were no extension cords available for staff to use that were sufficient in length to reach from one of two outlets connected to the generator on the first floor to the second and third floors. The maintenance person reported that they had to go to their personal residence to acquire a 100-foot cord, which was necessary to reach the other two floors.

No electrical outlets are connected to the generator power on either second or third floor.

An insufficient amount of linen was observed in the laundry room for emergencies. According to the laundry aide, the amount that was stored in the laundry room was sufficient for day to day needs and was not part of the emergency supply. No storage rooms contained the required supply.

The licensee's emergency plan related to a loss of essential services (Code Grey) did not include home-specific information about the supplies, equipment, and resources they needed to manage in such an emergency. The emergency manual acquired from Extendicare included direction for the home to ensure that they had an adequate supply of extension cords (one for every 10 beds) in designated areas of the home and to have some flashlights at the nurse's station. There was no other information about other supplies, equipment and resources necessary for their specific needs.

Sources: Interviews (Administrator, maintenance, dietary and nursing staff); Record Review (Spec Sheet for StanPro Emergency Light, Steel Battery Unit, Code Grey - Loss of Essential Services EP-09-01-02 and Generator Break Panel documents).

[736409]

WRITTEN NOTIFICATION: Emergency Plans

NC #4 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (5) 4.

The licensee failed to ensure emergency plans address specific staff roles and responsibilities.

Rational and Summary

The licensee's Code Grey plan to address a loss of essential services during a power outage, was developed by their managing company, Extendicare. The plans were general in nature so as to provide a basic framework to any long-term care home that they owned or managed. The Code included direction for the home to implement preventive, preparedness, responsive and recovery procedures when managing a Code-Grey – Essential Services event, in alignment with their home- specific Hazard Identification and Risk Analysis, to ensure the safety of the occupants of the home and the continuity of resident care.

An Incident Manager Checklist was included in the plan and was developed for the administrator or designate to complete. Their role also included directing floor staff to complete certain tasks. However, the incident manager, or administrator in this case, was not present across all shifts, so staff were not all informed equally on how to manage a power loss situation. The plan directed staff to use checklists for dietary, nursing and maintenance, with specific tasks or actions to complete to manage the loss of essential services. No specific tasks were assigned to office staff, personal support workers, housekeeping, laundry or activation staff. Checklists were not customized to the home.

During a power outage on December 23, 2022, that lasted over 12 hours, whereby the services were either not available or limited for the duration of the outage, multiple staff complaints were received about the lack of direction that was available in writing for their position and that some staff could not find their emergency response binder. The training that they received was based on the emergency plan that was not enhanced with the specifics of their building design, equipment, and resident population.

Missing from the plan included but was not limited to:

- Equipment and methods available to staff to evacuate residents from the upper floors when elevators are not functional.
- Specifically, what was required in the home's disaster box and the number of each item. Extension cords were missing during the outage and an insufficient number of alternative lights were provided.
- The location of emergency supplies such as personal protective equipment, linens, hand sanitizer, paper products, blankets, writing paper and forms, and other essential supplies.
- What specifically laundry staff will do when their washing and drying machines are not functioning during a power outage and how linens will be provided during an extended power outage.
- What duties housekeeping staff will complete during a power outage.
- Nursing staff checklist focused on what to do when internet connectivity was lost and to document resident care on paper. There were no specific duties for personal support workers, and what alternatives were available to them regarding personal hygiene, lifts and transfers (if batteries are not able to be

recharged), and how residents with electric beds and electrical devices will be managed.
- The maintenance checklist did not include any other tasks other than to ensure the generator was functional and that there was enough fuel on site and that could be delivered. The home's generator used natural gas.
- The dietary checklist did not include the need to monitor refrigeration temperatures of the refrigerators on floors two and three, did not include that electrical outlets were not on a backup power supply in the kitchen or the serveries on floors two and three, what equipment was available to staff to transport food and fluids up and down stairs, what specific sister homes staff were required to contact for assistance, which refrigeration back-up company to contact, what alternative lighting could be used in the kitchen and dining rooms, where their emergency supplies were located (paper products), and how cooking and preparation utensils and equipment were to be washed and sanitized (when dishwasher has no power).

Staff not being provided with sufficient direction and a clear understanding of their specific roles and responsibilities during an emergency may impact their ability to respond quickly and appropriately to ensure residents are safe and secure.

Source: Record Review (Loss of essential services checklist) Interviews (administrator, maintenance, dietary and nursing staff)

[736409]

WRITTEN NOTIFICATION: Emergency Plans

NC #5 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (14)

The licensee failed to ensure that staff, volunteers, and students were trained on the emergency plans,

(a) before they performed their responsibilities; and
(b) at least annually thereafter.

Rational and Summary

The ministry received a complaint from staff identifying that there was no emergency training provided and there was no management support during the power outage that occurred on December 23, 2022.

The administrator stated that staff received emergency response training as part of the Surge Web based application training. Surge training is completed once a year plus month drills. Surge training did not include the emergency plans training as per the legislation.

Failing to have an adequate emergency response staff training program could potentially result in staff not being able to respond quickly and appropriately during an emergency which may impact the safety and security of residents.

Source: Interviews (Administrator, Office Manager, Director of Care, Dietary and Environmental Manager and other staff, Record Review (Surge training - emergency content for loss of essential services, Emergency Response Manual)

[736409]

COMPLIANCE ORDER [CO #1] [Generators]

NC #6 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 22 (3)

Compliance Plan [FLTCA, 2021, s. 155 (1) (b)

Specifically, the licensee shall prepare, submit, and implement a plan that identifies how the licensee will ensure that the existing generator and/or any additional generators will maintain the following during a power outage:

- the heating system,
- emergency lighting in hallways, corridors, stairways and exits,
- dietary services equipment required to store food at safe temperatures (steam tables, refrigeration) and prepare meals and snacks (blenders, steamers, mixers, ovens, stoves),
- the resident-staff communication and response system,
- elevators and life support (oxygen, CPAP, and other medical equipment), safety and emergency equipment (magnetic door locking systems, fire safety equipment)

Please submit the written plan for achieving compliance for inspection #2022- 1149-002 to Kwesi Douglas (736409), LTC Homes Inspector, MLTC, by email to hamiltondistrict.mltc@ontario.ca by March 24, 2023.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

The licensee did not ensure that there was guaranteed access to a generator that was operational within three hours of the power outage and that was able to maintain the required services listed below:

- Emergency lighting in the hallways
- Dietary services equipment
- Resident-staff communication and response system
- Elevator
- Heating
- Safety and emergency equipment

The licensee had a small generator with a maximum capacity of 9000 watts on site and connected to the electrical panel. According to a record provided by the maintenance person, the generator was capable of servicing the heat pumps from the hot water boiler for home heating, the magnetic door locks, telephone system and fire alarm systems and a few electrical outlets on the main or first floor. The document identified that the generator did not service any elevators and emergency lights or electrical outlets that could service the kitchen appliances and refrigeration, resident home areas on the second and third floors, including the vaccine refrigerator, servery steam tables and refrigerators. Excluded from the document was any information about their resident-staff communication and response system (RSCRS) which requires electricity to operate.

Emergency lights in corridors were powered by a battery and the specifications on the unit indicated a battery run time of 30 minutes. The RSCRS did not have a battery backup system or was connected to the generator. Therefore, neither of these systems were functional for the duration of the power outage that began on December 23, 2022

and lasted until December 24, 2022.

On December 23, 2022, at approximately 5 p.m. the generator did not start when the power went out and it was determined that the gas line to the generator froze. Management reached out to the contracted service provider for a backup generator, however a generator was not going to be available until the following day. Management reached out to another generator company and a technician attended to the generator and determined that the cause of the failure was a frozen gas line. The generator was restored by 11:15 p.m. The hydro for the home returned on December 24, 2022, at 6:30 a.m.

During the power outage between 5 p.m. and 11:15 p.m., on December 23, 2022, the RSCRS, lighting systems, magnetic door locks on stairwell doors and the main door, the vaccine refrigerator, fire alarms, the servery refrigerators, the kitchen refrigerator and freezer units, dishwasher, kitchen lighting, heating pumps, mechanical beds and elevators were not working. Although there was no report of resident harm, the potential for harm was high as the key safety operational systems were not functioning.

A generator service contract was provided upon request; however, the contract was a preventative maintenance contract. No generator service contract for the delivery of the generator within three hours of a power outage. was observe at the time of inspection. It was observed that the onsite generator was located on a hill at the side of the building. Management stated that they were in the process of securing a new service provider to ensure an external generator can be delivered and connected within three hours, should there be a future power outage. However, the administrator nor the maintenance person, both who were newly hired, did not know how the additional generator could be connected to the electrical panel or where it would be placed once delivered. This information was not included in any of the documentation collected during the inspection.

The impact to the residents was moderate during the incident as essential services that are required to be powered by a generator could not be provided during the power outage. These conditions can potentially lead to the actual harm of residents.

Sources: Interviews (Administrator, DOC, Office Manager, Dietary and Environmental Manager and other staff), Records (emergency lights specifications, Code Grey- Loss of Essential Services, Generator policy, generator maintenance contract).

[736409]

This order must be complied with by June 30, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review. Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(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, email or commercial courier upon:

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.

- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board	**Director**
Attention Registrar 151 Bloor Street West,9th Floor Toronto, ON M5S 1S4	c/o Appeals Coordinator Long-Term Care Inspections Branch Ministry of Long-Term Care 438 University Avenue, 8th Floor Toronto, ON M7A 1N3 email: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137