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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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 4, 2016	2016_189120_0043	017848, 017852, 018103-16	Complaint

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

COOKSVILLE CARE CENTRE
55 THE QUEENSWAY WEST MISSISSAUGA ON L5B 1B5

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 Complaint inspection.

This inspection was conducted on the following date(s): July 7, 2016

Three separate complaints were received related to loss of essential services on June 12, 2016.

During the course of the inspection, the inspector(s) spoke with the Director of Operations, Director of Care, Environmental Services Supervisor, Food Services Supervisor, Activities Supervisor, registered and non-registered nursing staff, activation staff, housekeepers, maintenance person, residents and families.

During the course of the inspection, the inspector reviewed the home's emergency supplies, emergency procedures, emergency generator contract and toured the home.

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)**
- **3 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. 19. Generators

Specifically failed to comply with the following:

s. 19. (4) The licensee of a home to which subsection (2) or (3) applies shall ensure, not later than six months after the day this section comes into force, that the home has guaranteed access to a generator that will be operational within three hours of a power outage and that can maintain everything required under clauses (1) (a), (b) and (c). O. Reg. 79/10, s. 19 (4).

Findings/Faits saillants :

1. The licensee did not ensure that a generator was operational within 3 hours of a power

outage and that was able to maintain the required services as identified below:

*emergency lighting in hallways, corridors, stairways and exits
*heating
*dietary services equipment
*resident-staff communication and response system
*elevators and life support
*safety and emergency equipment (fire panel, magnetic door locking systems)

The home (classified as structural class C home) did not have have a generator on site within 3 hours of the power outage that affected the home between 3 a.m. and 7 p.m. on June 12, 2016 and that could support all of the essential services listed above. The power outage occurred after an animal got caught in the wires of their power transformer which is located on the home's property. The home was equipped with battery operated emergency lighting (lasting approximately 7 hours) and a small portable generator which did not operate beyond several hours for some minor services. Several years prior, a transfer switch was installed within the home for the ability to connect to a larger portable generator. The licensee had a contract dated June 12, 2014 with a contractor to deliver a generator within 3 hours of the power outage but chose not to pursue this option believing that the transformer could be repaired by mid morning.

According to accounts from staff, families and residents the following concerns were identified related to the lack of essential services listed above:

1. The magnetic locking systems for the stairwell doors and the perimeter exit doors were not functional and in response, the licensee had some doors monitored by staff and others were blocked with carts.
2. No alternative to the resident-staff communication and response system was available with the exception of staff conducting rounds.
3. The corridors were very dark and it was difficult to see. No emergency lights were available and the exit stairwell door signs were not illuminated. The extra batteries for the flashlights did not all work and some were not charged. No portable lamps were available.
4. As the home did not have openable windows and relied on incremental heating, cooling and ventilation units, the rooms were hot and stuffy. The balcony door in the dining room on each floor and stairwell doors had to be opened to induce cross ventilation. No air temperature monitoring was conducted to determine when and if residents needed to be evacuated to a cooling area to manage heat related symptoms.

5. Some of the mechanical floor lifts were non-functional, either due to dead batteries or batteries that were not fully charged. Several residents interviewed remained in bed throughout the duration of the outage.
6. Residents had to remain on their respective floors. Not all staff received training in the use of the "evacu chairs" located in the stairwells.
7. Residents therapeutic mattresses deflated and alternative mattresses were not provided to residents.
8. No refrigeration or hot holding equipment was available to ensure food temperatures remained at safe temperatures. No food temperature logs were available for review when foods were transported out of the home to another facility and what temperatures were achieved during the cooking or re-heating process on the Bar-B-Q.

This Order is based upon 3 factors, severity, scope and history of non-compliance in keeping with section 299(1) of the Long Term Care Home Regulation 79/10. The severity was 2 (potential for harm/risk), the scope was 3 (widespread - loss of many services affected every occupant) and the compliance history was 3 (previously issued in the same area). An Order was previously issued related to this section on August 28, 2013 following a power outage that lasted 8 hours on July 9, 2013. [s. 19. (4)]

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. 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).

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 :

1. The licensee did not ensure that their emergency plans provided for the loss of one or more essential services, specifically the loss of elevator and life support, safety and emergency equipment and the loss of the resident-staff communication and response system.

No written plans for the above identified essential services were available for review. As per the "Loss of Hydro" plan (EPM I-05-10 dated De 9/13), the reader was referred to "additional emergency procedures". However, the list did not include any reference to any plans for the management of a loss of elevator service and life support, safety and emergency equipment or the resident-staff communication and response system.

Essential services, as defined by section 19 of Ontario Regulation 79/10 includes emergency lighting, heating, dietary services equipment required to store food at safe temperatures and prepare and deliver meals and snacks, the resident-staff communication and response system, elevators and life support (i.e. PEG tube feeding

systems, oxygen, dialysis, therapeutic surfaces), safety and emergency equipment (i.e magnetic door locking system, fire alarm system, fire panel, resident transport equipment). The home's "Loss of Hydro" plan identified some direction with respect to loss of heat during cold weather and the failure of the magnetic locking system but the information was not developed in accordance with s. 230(5) on Ontario Regulation 79/10.

During the power outage on June 12, 2016 that lasted over 12 hours, the elevators, the magnetic door locking system, fire panel, fire alarm system, resident-staff communication and response system were all affected. No written information and guidance was available to staff who were present on June 12, 2016 to deal with the loss of these services. [s. 230. (4) 1.]

2. The licensee did not ensure that emergency plans related to loss of essential services addressed the following components:

1. Plan activation.
2. Lines of authority.
3. Communications plan.
4. Specific staff roles and responsibilities.

The licensee's available plans were reviewed for the following:

A) Interruption of Dietary Services (EPM I-05-05, dated April 1, 2013)
B) Loss of Hydro (EPM I-05-10 dated Dec. 9/13)

On June 12, 2016, no hydro was available to support all essential services between 3 a.m. and 7 p.m. The home did not have a generator on site that could operate all essential services for the duration of the outage. During this time, all of the essential services previously identified under #1 above were affected.

A) On June 12, 2016, three meals and 2 snack services were affected. The "Interruption of Dietary Services" plan did not include under what circumstances the plan would be activated, did not include lines of authority, a communications plan and specific staff roles and responsibilities.

The dietary plan did not include a statement as to when or how the plan would be activated. The only statement in the plan included "the home shall have in place a plan and be prepared to deal with an interruption in Food Services in a way that minimizes

disruption to the residents". This statement did not adequately identify what types of interruptions would be included in order for the full plan (or components) to be activated.

The dietary plan did not include any lines of authority other than reference to the Food Services Supervisor (FSS) being the person to "delegate staff to go to alternate locations to assist with food preparation". The plan did not include who would be in authority if the FSS was not available and what other staff positions would be involved in delegating certain matters.

The dietary plan did not include a communications protocol such as how staff would be informed of changes to procedures, menus, service delivery and how those changes would be communicated.

The dietary plan did not include specific staff responsibilities. Under the "Loss of Hydro" plan, general dietary staff responsibilities included "begin discussing menu changes" or "use of contingency meal plans" and "begin recording temperatures of refrigerators and freezers". The dietary staff included cooks, dish washers and preparation staff who all have various roles. However, the plan did not identify their specific responsibilities and the expected outcome of the plan was that "all key people have knowledge and understanding of contingency protocol".

No contingency meal plans were available on June 12, 2016 for regular, pureed or minced diets which included alternatives and menus for specialized diets (gluten-free, vegetarian, diabetic or renal). According to the FSS, she made changes to the regular menu that day and made immediate decisions based on her training and past experience. However, if she had not been available, other staff in the home would not have had a pre-planned contingency meal plan for guidance.

No temperature logs were available for review for those foods that were transported from the home to another facility or temperatures for foods that were re-heated or cooked on the outdoor Bar-B-Q.

B) On June 12, 2016, resident care services (baths/showers), transfers to and from bed, comfort, safety, recreational activities and freedom of movement were affected for over 12 hours. The "Loss of Hydro" plan did not include a line of authority beyond management staff, no communications plan and no specific staff roles and responsibilities.

The "Loss of Hydro" plan included lines of authority for the Administrator who was to take the lead on activating their code grey. On June 12, 2016, the Administrator was not available. The secondary lead was identified as the Director of Nursing who was also off site on that day but available by telephone. The VP of Operations was also listed as someone who would be involved if the power outage was anticipated to be of "long duration". The VP of Operations was confirmed to have been involved in making arrangements to have the power restored but was not on site. The ESS and the FSS were the only managers on site on the day of the outage.

Several complaints were received from family members that upper management were not on site and that registered staff who were on site during the outage did not seem to know what to do or were unaware of any emergency plans, especially after the sun set and the home would fall into complete darkness.

The "Loss of Hydro" plan did not include a communications protocol that included as a minimum how staff would be informed of changes to procedures, service delivery and how those changes would be communicated to all necessary individuals. The plan did not include how and when to contact families if necessary and if they would need to become involved. During the power outage on June 12, 2016, no family members were notified of the outage. On June 13, 2016, families were specifically notified that the home's phone lines were not functional and given an alternative number to contact. No reason was provided as to why the lines were down. Post incident, the families were not informed as to what occurred and how services were provided during the outage. Staff working at the time of the outage reported that they used their own personal cell phones to make calls. According to the licensee's "Loss of Communication" plan, reference was made to use the "home cell phone". The plan identified that "staff will be requested to run messages to all floors/departments".

Specific department roles were listed in the "Loss of Hydro" plan but the staff responsibilities were limited. An example of one out of two responsibilities listed for both the laundry and housekeeping staff included "reporting to the nearest nursing station to await instructions" or "report to Director of Nursing or Delegate and await direction". No guidance was available for the delegate or registered staff at the nursing station to provide to staff in either department.

No person was delegated to monitor air temperatures during the outage. According to accounts from staff, family and residents, the only ventilation that could be provided on

June 12, 2016 was to open the stairwell doors and the balcony doors on each floor. Confirmation was made at time of inspection that none of the windows in the home were designed to open and rooms were provided with incremental heating, ventilation and air conditioning units only. Without power, no ventilation would have been available other than through balcony and stairwell doors. At the time of inspection, no temperature logs could be provided for the 2nd and 3rd floors for any time period over the last 3 months. The nursing staff identified the environmental staff being responsible for monitoring air temperatures and environmental staff thought it was a nursing staff duty.

This Order is based upon 3 factors, severity, scope and history of non-compliance in keeping with section 299(1) of the Long Term Care Home Regulation 79/10. The severity was 2 (potential for harm/risk), the scope was 3 (widespread - loss of services affected every occupant) and the compliance history was 3 (previously issued in the same area). An Voluntary Plan of Compliance was previously issued related to this section on August 28, 2013. [s. 230. (5)]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 4th day of August, 2016

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

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

Ministére 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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2016_189120_0043
Log No. / Registre no:	017848, 017852, 018103-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 4, 2016
Licensee / Titulaire de permis :	RYKKA CARE CENTRES LP 3200 Dufferin Street, Suite 407, TORONTO, ON, M6A-3B2
LTC Home / Foyer de SLD :	COOKSVILLE CARE CENTRE 55 THE QUEENSWAY WEST, MISSISSAUGA, ON, L5B-1B5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	NICOLE FISHER

To RYKKA CARE CENTRES LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Ministére 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

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

Ministére 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

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 19. (4) The licensee of a home to which subsection (2) or (3) applies shall ensure, not later than six months after the day this section comes into force, that the home has guaranteed access to a generator that will be operational within three hours of a power outage and that can maintain everything required under clauses (1) (a), (b) and (c). O. Reg. 79/10, s. 19 (4).

Order / Ordre :

The licensee shall prepare and submit a plan which summarizes how the services required under clauses 1(a), (b) and (c) of section 19 of Ontario Regulation 79/10 will be maintained within 3 hours of a power loss. The plans are required regardless of whether a generator is permanently available on the site or not.

The plan shall be implemented and submitted via email to Bernadette.susnik@ontario.ca by September 16, 2016.

Grounds / Motifs :

1. The licensee did not ensure that a generator was operational within 3 hours of a power outage and that was able to maintain the required services as identified below:

*emergency lighting in hallways, corridors, stairways and exits
*heating
*dietary services equipment
*resident-staff communication and response system
*elevators and life support
*safety and emergency equipment (fire panel, magnetic door locking systems)

The home (classified as structural class C home) did not have have a generator on site within 3 hours of the power outage that affected the home between 3 a.m. and 7 p.m. on June 12, 2016 and that could support all of the essential

services listed above. The power outage occurred after an animal got caught in the wires of their power transformer which is located on the home's property. The home was equipped with battery operated emergency lighting (lasting approximately 7 hours) and a small portable generator which did not operate beyond several hours for some minor services. Several years prior, a transfer switch was installed within the home for the ability to connect to a larger portable generator. The licensee had a contract dated June 12, 2014 with a contractor to deliver a generator within 3 hours of the power outage but chose not to pursue this option believing that the transformer could be repaired by mid morning.

According to accounts from staff, families and residents the following concerns were identified related to the lack of essential services listed above:

1. The magnetic locking systems for the stairwell doors and the perimeter exit doors were not functional and in response, the licensee had some doors monitored by staff and others were blocked with carts.
2. No alternative to the resident-staff communication and response system was available with the exception of staff conducting rounds.
3. The corridors were very dark and it was difficult to see. No emergency lights were available and the exit stairwell door signs were not illuminated. The extra batteries for the flashlights did not all work and some were not charged. No portable lamps were available.
4. As the home did not have openable windows and relied on incremental heating, cooling and ventilation units, the rooms were hot and stuffy. The balcony door in the dining room on each floor and stairwell doors had to be opened to induce cross ventilation. No air temperature monitoring was conducted to determine when and if residents needed to be evacuated to a cooling area to manage heat related symptoms.
5. Some of the mechanical floor lifts were non-functional, either due to dead batteries or batteries that were not fully charged. Several residents interviewed remained in bed throughout the duration of the outage.
6. Residents had to remain on their respective floors. Not all staff received training in the use of the "evacu chairs" located in the stairwells.
7. Residents therapeutic mattresses deflated and alternative mattresses were not provided to residents.
8. No refrigeration or hot holding equipment was available to ensure food temperatures remained at safe temperatures. No food temperature logs were available for review when foods were transported out of the home to another facility and what temperatures were achieved during the cooking or re-heating

process on the Bar-B-Q.

This Order is based upon 3 factors, severity, scope and history of non-compliance in keeping with section 299(1) of the Long Term Care Home Regulation 79/10. The severity was 2 (potential for harm/risk), the scope was 3 (widespread - loss of many services affected every occupant) and the compliance history was 3 (previously issued in the same area). An Order was previously issued related to this section on August 28, 2013 following a power outage that lasted 8 hours on July 9, 2013. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 16, 2016

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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.
2. Evacuation of the home, including a system in the home to account for the whereabouts of all residents in the event that it is necessary to evacuate and relocate residents and evacuate staff and others in case of an emergency.
3. Resources, supplies and equipment vital for the emergency response being set aside and readily available at the home.
4. Identification of the community agencies, partner facilities and resources that will be involved in responding to the emergency. O. Reg. 79/10, s. 230 (4).

Order / Ordre :

1. The licensee shall develop written emergency plans for a loss of elevator and life support, safety and emergency equipment and the loss of the resident-staff communication and response system that includes the following components:

1. Plan activation.
2. Lines of authority.
3. Communications plan.
4. Specific staff roles and responsibilities.

The plans shall also include the identity, if applicable, of a community agency or partner facility that would be involved in responding to the emergency and a copy of the plans shall be provided to those identified agencies and partner facilities.

2. The completed plans shall be reviewed with all staff, the family council and resident council.

3. The plans shall be tested annually with all staff and those identified community agencies and partner facilities identified in the plans that would be involved in responding to the emergencies.

Grounds / Motifs :

1. The licensee did not ensure that their emergency plans provided for the loss of one or more essential services, specifically the loss of elevator and life support, safety and emergency equipment and the loss of the resident-staff communication and response system.

No written plans for the above identified essential services were available for review. As per the "Loss of Hydro" plan (EPM I-05-10 dated De 9/13), the reader was referred to "additional emergency procedures". However, the list did not include any reference to any plans for the management of a loss of elevator service and life support, safety and emergency equipment or the resident-staff communication and response system.

Essential services, as defined by section 19 of Ontario Regulation 79/10 includes emergency lighting, heating, dietary services equipment required to store food at safe temperatures and prepare and deliver meals and snacks, the resident-staff communication and response system, elevators and life support (i.e. PEG tube feeding systems, oxygen, dialysis, therapeutic surfaces), safety and emergency equipment (i.e magnetic door locking system, fire alarm system, fire panel, resident transport equipment). The home's "Loss of Hydro" plan identified some direction with respect to loss of heat during cold weather and the failure of the magnetic locking system but the information was not developed in accordance with s. 230(5) on Ontario Regulation 79/10.

During the power outage on June 12, 2016 that lasted over 12 hours, the elevators, the magnetic door locking system, fire panel, fire alarm system, resident-staff communication and response system were all affected. No written information and guidance was available to staff who were present on June 12, 2016 to deal with the loss of these services. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2016

Order # / Ordre no : 003

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 :

The licensee shall revise or amend their existing emergency plans related to;

A) Interruption of Dietary Services (EPM I-05-05, dated April 1, 2013)
B) Loss of Hydro (EPM I-05-10 dated Dec. 9/13)

to include the following components:

1. Plan activation.
2. Lines of authority.
3. Communications plan.
4. Specific staff roles and responsibilities.

The plans shall also include the identity, if applicable, of a community agency or partner facility that would be involved in responding to the emergency and a copy of the plans shall be provided to those identified agencies and partner facilities.

2. The revised plans shall be reviewed with all staff, the family council and resident council.

3. The plans shall be tested annually with all staff and those identified community agencies and partner facilities identified in the plans that would be involved in responding to the emergencies.

Grounds / Motifs :

1. The licensee did not ensure that emergency plans related to loss of essential services addressed the following components:

1. Plan activation.
2. Lines of authority.
3. Communications plan.
4. Specific staff roles and responsibilities.

The licensee's available plans were reviewed for the following:

A) Interruption of Dietary Services (EPM I-05-05, dated April 1, 2013)
B) Loss of Hydro (EPM I-05-10 dated Dec. 9/13)

On June 12, 2016, no hydro was available to support all essential services between 3 a.m. and 7 p.m. The home did not have a generator on site that could operate all essential services for the duration of the outage. During this time, all of the essential services previously identified under #1 above were affected.

A) On June 12, 2016, three meals and 2 snack services were affected. The "Interruption of Dietary Services" plan did not include under what circumstances the plan would be activated, did not include lines of authority, a communications plan and specific staff roles and responsibilities.

The dietary plan did not include a statement as to when or how the plan would be activated. The only statement in the plan included "the home shall have in place a plan and be prepared to deal with an interruption in Food Services in a way that minimizes disruption to the residents". This statement did not adequately identify what types of interruptions would be included in order for the full plan (or components) to be activated.

The dietary plan did not include any lines of authority other than reference to the Food Services Supervisor (FSS) being the person to "delegate staff to go to alternate locations to assist with food preparation". The plan did not include who would be in authority if the FSS was not available and what other staff positions would be involved in delegating certain matters.

The dietary plan did not include a communications protocol such as how staff

would be informed of changes to procedures, menus, service delivery and how those changes would be communicated.

The dietary plan did not include specific staff responsibilities. Under the "Loss of Hydro" plan, general dietary staff responsibilities included "begin discussing menu changes" or "use of contingency meal plans" and "begin recording temperatures of refrigerators and freezers". The dietary staff included cooks, dish washers and preparation staff who all have various roles. However, the plan did not identify their specific responsibilities and the expected outcome of the plan was that "all key people have knowledge and understanding of contingency protocol".

No contingency meal plans were available on June 12, 2016 for regular, pureed or minced diets which included alternatives and menus for specialized diets (gluten-free, vegetarian, diabetic or renal). According to the FSS, she made changes to the regular menu that day and made immediate decisions based on her training and past experience. However, if she had not been available, other staff in the home would not have had a pre-planned contingency meal plan for guidance.

No temperature logs were available for review for those foods that were transported from the home to another facility or temperatures for foods that were re-heated or cooked on the outdoor Bar-B-Q.

B) On June 12, 2016, resident care services (baths/showers), transfers to and from bed, comfort, safety, recreational activities and freedom of movement were affected for over 12 hours. The "Loss of Hydro" plan did not include a line of authority beyond management staff, no communications plan and no specific staff roles and responsibilities.

The "Loss of Hydro" plan included lines of authority for the Administrator who was to take the lead on activating their code grey. On June 12, 2016, the Administrator was not available. The secondary lead was identified as the Director of Nursing who was also off site on that day but available by telephone. The VP of Operations was also listed as someone who would be involved if the power outage was anticipated to be of "long duration". The VP of Operations was confirmed to have been involved in making arrangements to have the power restored but was not on site. The ESS and the FSS were the only managers on site on the day of the outage.

Several complaints were received from family members that upper management were not on site and that registered staff who were on site during the outage did not seem to know what to do or were unaware of any emergency plans, especially after the sun set and the home would fall into complete darkness.

The "Loss of Hydro" plan did not include a communications protocol that included as a minimum how staff would be informed of changes to procedures, service delivery and how those changes would be communicated to all necessary individuals. The plan did not include how and when to contact families if necessary and if they would need to become involved. During the power outage on June 12, 2016, no family members were notified of the outage. On June 13, 2016, families were specifically notified that the home's phone lines were not functional and given an alternative number to contact. No reason was provided as to why the lines were down. Post incident, the families were not informed as to what occurred and how services were provided during the outage. Staff working at the time of the outage reported that they used their own personal cell phones to make calls. According to the licensee's "Loss of Communication" plan, reference was made to use the "home cell phone". The plan identified that "staff will be requested to run messages to all floors/departments".

Specific department roles were listed in the "Loss of Hydro" plan but the staff responsibilities were limited. An example of one out of two responsibilities listed for both the laundry and housekeeping staff included "reporting to the nearest nursing station to await instructions" or "report to Director of Nursing or Delegate and await direction". No guidance was available for the delegate or registered staff at the nursing station to provide to staff in either department.

No person was delegated to monitor air temperatures during the outage. According to accounts from staff, family and residents, the only ventilation that could be provided on June 12, 2016 was to open the stairwell doors and the balcony doors on each floor. Confirmation was made at time of inspection that none of the windows in the home were designed to open and rooms were provided with incremental heating, ventilation and air conditioning units only. Without power, no ventilation would have been available other than through balcony and stairwell doors. At the time of inspection, no temperature logs could be provided for the 2nd and 3rd floors for any time period over the last 3 months. The nursing staff identified the environmental staff being responsible for

monitoring air temperatures and environmental staff thought it was a nursing staff duty.

This Order is based upon 3 factors, severity, scope and history of non-compliance in keeping with section 299(1) of the Long Term Care Home Regulation 79/10. The severity was 2 (potential for harm/risk), the scope was 3 (widespread - loss of services affected every occupant) and the compliance history was 3 (previously issued in the same area). An Voluntary Plan of Compliance was previously issued related to this section on August 28, 2013. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2016

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

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
Ontario, ON
M5S-2B1
Fax: 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
Ontario, ON
M5S-2B1
Fax: 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 4th day of August, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BERNADETTE SUSNIK

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