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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Apr 19, 2017	2017_539120_0019	025539-16, 025541-16, 025543-16	Follow up

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 Follow up inspection.

This inspection was conducted on the following date(s): March 16, 2017

An inspection (2016-189120-0043) was previously conducted on July 7, 2016 following complaints from families about a power outage at the home. Non-compliance was identified related to the home's emergency plans and three separate orders were issued. For this follow-up inspection, all three orders remain outstanding.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Food Services Supervisor, maintenance person and personal support workers (PSWs).

During the course of the inspection, the inspector toured the third and first floors and reviewed the home's emergency plans.

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. 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.

An order was previously issued on August 4, 2016, requiring the licensee to develop emergency plans that included the above identified essential services. During this inspection, the most current emergency plans were requested for review and provided by the Administrator. No written plans were developed for loss of elevator and life support, safety and emergency equipment and the loss of the resident-staff communication and response system.

As per the "Loss of Hydro" plan (EPM I-05-10 revised January 10, 2017), 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(1)(a), (b) and (c) 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 a 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 essential services. [s. 230. (4) 1.]

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

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

An order was previously issued on August 4, 2016, requiring the licensee to revise and amend existing emergency plans identified as "Interruption of Dietary Services" (EPM I-05-05 April 1, 2013) and "Loss of Hydro" (EPM I-05-10 December 9, 2013) to include the following components;

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

During this inspection, the above two noted emergency plans were provided by the

Administrator. No changes were made to the "Interruption of Dietary Services" plan. The "Loss of Hydro" plan included two additional responsibilities for the Environmental Services Manager and no other changes. The plan was revised on January 10, 2017.

On June 12, 2016, no hydro was available 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 were affected and included the following;

*emergency lighting in hallways, corridors, stairways and exits
*heating
*dietary services equipment
*resident-staff communication and response system
*elevators and life support

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.

1. The dietary plan did not include a statement as to when or how the plan would be activated. The plan included that "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.

2. 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.

3. 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.

4. The dietary plan did not include specific staff roles and responsibilities. According to 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". No guidance was provided as to which contingency meal plans to use or where they could be found and who would monitor refrigerators, freezers and food temperatures, how often and at what point foods would become unsafe for consumption.

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, changes were made to the regular menu that day and immediate decisions were made based on their training and many years of past experience dealing with power outages or breakdown of dietary equipment. If the FSS were not available on June 12, 2016, other staff in the home would not have had a pre-planned contingency meal plan for guidance. No temperature logs were available for review during the inspection for those foods that were transported from the home to another facility for further preparation or temperatures for foods that were re-heated or cooked on the outdoor Bar-B-Q at the home site.

The dietary staff included cooks, dish washers and preparation staff who all had various roles. However, neither of the two plans identified included specific roles and responsibilities during a loss of dietary equipment (refrigerators, stoves, hot holding equipment, dish washing, blenders, mixers etc). The expected outcome of the plan was that "all key people have knowledge and understanding of contingency protocol". The statement however did not identify who the "key people" were and how they would have the "knowledge and understanding of the contingency protocol" when it had not been developed.

During this inspection, the Food Services Manager confirmed that no changes had been made to the "Interruption of Dietary Services" emergency plan and that she was not requested to review the plan to make any changes.

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 communications plan and no specific staff roles and responsibilities for various staff members.

1. The "Loss of Hydro" plan included lines of authority for the various managerial positions in the home, however the lack of specific roles and responsibilities in the plan created confusion. The Administrator, who was to take the lead on activating their Code

Grey (loss of power) Policy during regular business hours, was not available as the incident occurred on a Sunday. For after hours, the plan identified the Charge Nurse as the lead in activating the Code Grey Policy which included contacting the Environmental Services Manager (ESM). The ESM was on site and they contacted the Director of Nursing who was not working but was 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. Several complaints were received from family members that upper management were not on site and that the "Charge Nurses" who were on site during the outage did not seem to know what to do or were unaware of any emergency plans, especially the details necessary to manage residents after sun set. Specific department roles were listed in the "Loss of Hydro" plan but the staff responsibilities were limited.

The plan included only two responsibilities for the laundry, housekeeping and program staff. They included “shut off equipment or secure equipment and report to the nearest nursing station to await further instructions”. No guidance was available for the managers, delegate or any registered staff member who would need to direct other staff during a power outage or failure of any essential service.

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

a) Staff and families reported that 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. The plan was confirmed to include the use of an "emergency kit" which listed flashlights/lanterns as available supplies. When the registered staff and charge nurses were interviewed, they reported that they did not have functional flashlights or enough lanterns to adequately keep certain areas illuminated for resident safety and to perform their jobs.

b) No alternative to the resident-staff communication and response system was available with the exception of staff conducting 15 minute rounds.

c) The home did not have windows that could be opened and were instead equipped with incremental heating, cooling and ventilation units. As the units did not work, 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. The plan did not identify what cooling areas were available. No person was delegated to monitor air temperatures during the power outage. At the time of inspection, no temperature logs could be provided for the 2nd and 3rd floors for any time period between March to June 2016. The nursing staff identified that the environmental staff were responsible for monitoring air temperatures and the environmental staff thought it was a duty of the nursing staff.

d) 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.

e) Residents had to remain on their respective floors for the duration of the outage. Not all staff received training in the use of the "evacu chairs" located in the stairwells. According to the staff co-ordinator/educator, all staff received information about the evacu-chair "on line" on April 30, 2016 and only a select few staff members received hands on training.

f) Residents therapeutic mattresses deflated and alternative mattresses were not provided to residents. According to the ESM, extra mattresses were available in the basement of the building, however staff did not report to the ESM that they required them.

2. 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 for staff to use the "home cell phone". The plan identified that "staff will be requested to run messages to all floors/departments". The plan did not include what staff members would be "running messages" and how the messages would be conveyed

(written or verbal). [s. 230. (5)]

Additional Required Actions:

CO # - 001, 003 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. 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. 1. The licensee did not ensure that the home had guaranteed access to a generator that was operational within 3 hours of a power outage and that was able to maintain everything required under clauses (1)(a), (b) and (c). The required services include the following essential 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)

An order was previously issued on August 4, 2016 requiring the licensee to prepare and submit a plan by September 16, 2016 which summarized how the essential services listed above, would be maintained within 3 hours of a power loss (with or without a permanent generator on site). The plan was required to ensure that the issues identified below do not re-occur.

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.

According to the plan submitted by the Administrator on September 16, 2016, the long term plan was to install a generator on site permanently by November 30, 2016, however, the home's maintenance person and the Director of Building Services confirmed that the generator was not on site. The generator that was previously ordered for the home was put on hold due to the change in Ontario Regulation 79/10 which extended the date for an "on site" generator to December 31, 2024. The contractor's agreement with the licensee was not current (dated June 12, 2014), identified that a minimum of 3 hours was required from time of call to time of generator delivery, did not guarantee delivery of the unit and did not include connections and terminations to the building or necessary permits and inspections.

According to the plan submitted by the Administrator, education was provided to all staff related to various emergency plans, including "loss of hydro" and "interruption of dietary services" and the use of "Evacu-chairs". Confirmation was provided by several PSWs and RNs that the education did not include any mock exercises or face to face interaction, which they felt would have been beneficial. Instead, individual emergency policies related to dietary services and loss of power were made available for review "on line" in February 2016 and June 2016. The policies were confirmed to be those missing the plan activation, lines of authority, communications plan and specific staff roles and responsibilities. The home's staff co-ordinator/educator reported that the last face to face exercise related to a loss of hydro was given in April 2014.

The plan submitted by the Administrator did not include how the emergency plans would be tested and when, when face to face mock training exercises with staff were held or going to be held and whether amendments to existing emergency plans or the development of missing emergency plans related to essential services were completed or scheduled to be completed. [s. 19. (4)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

Issued on this 8th day of May, 2017

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

Original report signed by the inspector.

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2017_539120_0019
Log No. / Registre no:	025539-16, 025541-16, 025543-16
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Apr 19, 2017
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:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant:
2016_189120_0043, CO #002;
2016_189120_0043, CO #003;

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 :

The licensee shall complete the following:

1. Develop individual written plans or amend the existing "Loss of Hydro" plan to include how the following essential services will be managed in the event of a power loss;

a. loss of elevator and life support, and
b. safety and emergency equipment, and
c. the resident-staff communication and response system.

2. The plan or individual plans shall include at a minimum when the plan is to be activated, lines of authority, a communications plan and staff roles and responsibilities.

3. The plan or individual plans shall be reviewed in detail with all staff in the home in a "face to face" training session or sessions.

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.

An order was previously issued on August 4, 2016, requiring the licensee to develop emergency plans that included the above identified essential services. During this inspection, the most current emergency plans were requested for review and provided by the Administrator. No written plans were developed for loss of elevator and life support, safety and emergency equipment and the loss of the resident-staff communication and response system.

As per the "Loss of Hydro" plan (EPM I-05-10 revised January 10, 2017), 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(1)(a), (b) and (c) 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 a 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 essential services.

This order is based upon three factors where there has been a finding of noncompliance in keeping with s.299(1) of Ontario Regulation 79/10. The factors include scope, severity and history of non-compliance. In relation to 230(4) of Ontario Regulation 79/10, the scope of the non-compliance is pattern, as more than one essential service is missing from the emergency plan, the severity of the non-compliance has the potential to cause harm to residents related to missing plans and the history of non-compliance is on-going as an order was previously issued on August 4, 2016.
(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2017

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2016_189120_0043, CO #001;

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 have in place the following:

1. A current contract or agreement with a generator supplier for the provision of a portable generator that can maintain everything required under clauses (1)(a), (b) and (c) of O. Reg. 79/10, s. 19(4); and

2. Clear direction that any staff member who is responsible for the building at any time, are aware of how to activate or when to activate the agreement; and

3. A protocol (either separate from the "Loss of Hydro" emergency plan or added as an appendix) that includes;

a. who will connect or terminate the power cables to the transfer switch within the building, b. what permits and inspections are required (if any) before the generator is started,
c. where the portable generator will be parked,
d. what barriers and equipment (if any) will need to be removed in order to run the cable(s) into the building,
e. through what access points the cable(s) will be brought into the building; and
f. what alternatives are available to the licensee if a generator rental cannot be obtained from the selected service provider.

Grounds / Motifs :

1. The licensee did not ensure that the home had guaranteed access to a generator that was operational within 3 hours of a power outage and that was able to maintain everything required under clauses (1)(a), (b) and (c). The required services include the following essential 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)

An order was previously issued on August 4, 2016 requiring the licensee to prepare and submit a plan by September 16, 2016 which summarized how the essential services listed above, would be maintained within 3 hours of a power loss (with or without a permanent generator on site). The plan was required to ensure that the issues identified below do not re-occur.

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.

According to the plan submitted by the Administrator on September 16, 2016, the long term plan was to install a generator on site permanently by November 30, 2016, however, the home's maintenance person and the Director of Building Services confirmed that the generator was not on site. The generator that was previously ordered for the home was put on hold due to the change in Ontario Regulation 79/10 which extended the date for an "on site" generator to December 31, 2024. The plan included that their generator contractor would be contacted to provide generator services within three hours of a power outage. The contractor's agreement with the licensee was not current (dated June 12, 2014), identified that a minimum of 3 hours was required from time of call to time of generator delivery, did not guarantee delivery of the unit and did not include connections and terminations to the building or necessary permits and inspections.

According to the plan submitted by the Administrator, education was provided to all staff related to various emergency plans, including "loss of hydro" and

"interruption of dietary services" and the use of "Evacu-chairs". Confirmation was provided by several PSWs and RNs that the education did not include any mock exercises or face to face interaction, which they felt would have been beneficial. Instead, individual emergency policies related to dietary services and loss of power were made available for review "on line" in February 2016 and June 2016. The policies were confirmed to be those missing the plan activation, lines of authority, communications plan and specific staff roles and responsibilities. The home's staff co-ordinator/educator reported that the last face to face exercise related to a loss of hydro was given in April 2014.

The plan submitted by the Administrator did not include how the emergency plans would be tested and when, when face to face mock training exercises with staff were held or going to be held and whether amendments to existing emergency plans or the development of missing emergency plans related to essential services were completed or scheduled to be completed.

This order is based upon three factors where there has been a finding of noncompliance in keeping with s.299(1) of Ontario Regulation 79/10. The factors include scope, severity and history of non-compliance. In relation to 19(4) of Ontario Regulation 79/10, the scope of the non-compliance is widespread, the severity of the non-compliance has the potential to cause harm to residents related to unclear or missing emergency plan direction and information and the history of non-compliance is on-going as an order was previously issued on August 11, 2014 and August 4, 2016.

(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2017

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 complete the following:

1. Amend or revise the existing emergency plan identified as "Interruption of Dietary Services" (EPM I-05-05 April 1, 2013) to include the following:

a. A clear statement that identifies what types of failures or emergencies would warrant the plan to be activated, when and how,
b. A statement that identifies the line of authority if the Food Services Supervisor is not available,
c. A communications protocol that identifies what needs to be communicated to staff, residents and families with respect to production, dietary procedures, menus, service delivery and how those changes would be communicated,
d. Specific staff roles and responsibilities for the cook, dish washer, dietary aides and food preparation staff in the event of dietary equipment breakdown or a loss of power.

2. Amend or revise the existing emergency plan identified as "Loss of Hydro" (EPM I-05-10 January 10, 2017) to include the following components;

a. communications protocol that identifies what needs to be communicated to staff, residents and families during the power outage and how,
b. Specific staff roles and responsibilities relating to the continuation of services with respect to the transport of equipment and supplies to various floors within the building, resident care equipment that relies on power to operate, loss of hot

water, loss of illumination levels, loss of heat, ventilation, door security, loss of the resident-staff communication and response system, personal care (baths/showers), recreational activities, ability to transport residents in and out of the building, laundry services, housekeeping services and maintenance services.

3. The amended or revised plans shall be shared with family council and resident council.

4. The amended or revised "Interruption of Dietary Services" plan shall be reviewed in detail with all dietary staff on all shifts in a "face to face" training session or sessions.

5. The amended or revised "Loss of Hydro" plan shall be reviewed in detail with all staff in the home on every shift in a "face to face" training session or sessions.

6. The amended or revised "Loss of Hydro" plan shall be tested by conducting a mock exercise involving any applicable partner facilities or community agencies and resources that will be involved in responding to an emergency. A written record of the testing of the emergency plan shall be kept.

Grounds / Motifs :

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

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

An order was previously issued on August 4, 2016, requiring the licensee to revise and amend existing emergency plans identified as "Interruption of Dietary Services" (EPM I-05-05 April 1, 2013) and "Loss of Hydro" (EPM I-05-10 December 9, 2013) to include the following components;

1. Plan activation.
2. Lines of authority.
3. Communications plan.

4. Specific staff roles and responsibilities.

During this inspection, the above two noted emergency plans were provided by the Administrator. No changes were made to the "Interruption of Dietary Services" plan. The "Loss of Hydro" plan included two additional responsibilities for the Environmental Services Manager and no other changes. The plan was revised on January 10, 2017.

On June 12, 2016, no hydro was available 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 were affected and included the following;

*emergency lighting in hallways, corridors, stairways and exits
*heating
*dietary services equipment
*resident-staff communication and response system
*elevators and life support

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.

1. The dietary plan did not include a statement as to when or how the plan would be activated. The plan included that "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.

2. 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.

3. The dietary plan did not include a communications protocol that identified what needed to be communicated to staff and residents with respect to

production, dietary procedures, menus, service delivery and how those changes would be communicated.

4. The dietary plan did not include specific staff roles and responsibilities. According to 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". No guidance was provided as to which contingency meal plans to use or where they could be found and who would monitor refrigerators, freezers and food temperatures, how often and at what point foods would become unsafe for consumption.

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, changes were made to the regular menu that day and immediate decisions were made based on their training and many years of past experience dealing with power outages or breakdown of dietary equipment. If the FSS were not available on June 12, 2016, other staff in the home would not have had a pre-planned contingency meal plan for guidance. No temperature logs were available for review during the inspection for those foods that were transported from the home to another facility for further preparation or temperatures for foods that were re-heated or cooked on the outdoor Bar-B-Q at the home site.

The dietary staff included cooks, dish washers and preparation staff who all had various roles. However, neither of the two plans identified included specific roles and responsibilities during a loss of dietary equipment (refrigerators, stoves, hot holding equipment, dish washing, blenders, mixers etc). The expected outcome of the plan was that "all key people have knowledge and understanding of contingency protocol". The statement however did not identify who the "key people" were and how they would have the "knowledge and understanding of the contingency protocol" when it had not been developed.

During this inspection, the Food Services Manager confirmed that no changes had been made to the "Interruption of Dietary Services" emergency plan and that she was not requested to review the plan to make any changes.

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

communications plan and no specific staff roles and responsibilities for various staff members.

1. The "Loss of Hydro" plan included lines of authority for the various managerial positions in the home, however the lack of specific roles and responsibilities in the plan created confusion. The Administrator, who was to take the lead on activating their Code Grey (loss of power) Policy during regular business hours, was not available as the incident occurred on a Sunday. For after hours, the plan identified the Charge Nurse as the lead in activating the Code Grey Policy which included contacting the Environmental Services Manager (ESM). The ESM was on site and they contacted the Director of Nursing who was not working but was 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. Several complaints were received from family members that upper management were not on site and that the "Charge Nurses" who were on site during the outage did not seem to know what to do or were unaware of any emergency plans, especially the details necessary to manage residents after sun set. Specific department roles were listed in the "Loss of Hydro" plan but the staff responsibilities were limited.

The plan included only two responsibilities for the laundry, housekeeping and program staff. They included “shut off equipment or secure equipment and report to the nearest nursing station to await further instructions”. No guidance was available for the managers, delegate or any registered staff member who would need to direct other staff during a power outage or failure of any essential service.

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

a) Staff and families reported that 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. The plan was confirmed to include the use of an "emergency kit" which listed flashlights/lanterns as available supplies. When the registered staff and charge nurses were interviewed, they reported that they did not have functional flashlights or enough lanterns to adequately keep certain

areas illuminated for resident safety and to perform their jobs.

b) No alternative to the resident-staff communication and response system was available with the exception of staff conducting 15 minute rounds.

c) The home did not have windows that could be opened and were instead equipped with incremental heating, cooling and ventilation units. As the units did not work, 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. The plan did not identify what cooling areas were available. No person was delegated to monitor air temperatures during the power outage. At the time of inspection, no temperature logs could be provided for the 2nd and 3rd floors for any time period between March to June 2016. The nursing staff identified that the environmental staff were responsible for monitoring air temperatures and the environmental staff thought it was a duty of the nursing staff.

d) 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.

e) Residents had to remain on their respective floors for the duration of the outage. Not all staff received training in the use of the "evacu chairs" located in the stairwells. According to the staff co-ordinator/educator, all staff received information about the evacu-chair “on line” on April 30, 2016 and only a select few staff members received hands on training.

f) Residents therapeutic mattresses deflated and alternative mattresses were not provided to residents. According to the ESM, extra mattresses were available in the basement of the building, however staff did not report to the ESM that they required them.

2. 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 for staff to use the "home cell phone". The plan identified that "staff will be requested to run messages to all floors/departments". The plan did not include what staff members would be "running messages" and how the messages would be conveyed (written or verbal).

This order is based upon three factors where there has been a finding of noncompliance in keeping with s.299(1) of Ontario Regulation 79/10. The factors include scope, severity and history of non-compliance. In relation to 230(5) of Ontario Regulation 79/10, the scope of the non-compliance is pattern, as more than one component is missing from the plans, the severity of the non-compliance has the potential to cause harm to residents related to missing information in the emergency plans and the history of non-compliance is on-going as an order was previously issued on August 4, 2016.
(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2017

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 19th day of April, 2017

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