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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 28, 2013	2013_189120_0052	H-000503-13	Critical Incident System

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): July 10, 2013

#2124-000015-13 related to a loss of essential services.

During the course of the inspection, the inspector(s) spoke with administrator and non-registered staff

During the course of the inspection, the inspector(s) reviewed the home's loss of hydro policy and procedures and verified that the home did not have a generator on the premises during the power outage between July 8 and July 9, 2013.

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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 :

The home (classified as a C home) did not have guaranteed access to a generator that was operational within 3 hours of the power outage that affected the home between 6:15 p.m. on July 8, 2013 and 3:30 a.m. July 9, 2013 and that could maintain 1) the heating system 2) emergency lighting in hallways, corridors, stairways and exits, 3) essential services including dietary services equipment required to store food at safe temperatures and prepare and deliver meals and snacks, 4) the resident-staff communication and response system, 5) elevators, 6) life support and safety and emergency equipment.

The City of Mississauga, where the home is situated, was affected by a wide area power outage due to a storm beginning at approximately 5:30 p.m July 8, 2013. The home was without power to operate their heating system (if needed), dietary services equipment, resident-staff communication and response system, lighting, elevators, safety and emergency equipment and life support equipment. The home was able to operate some emergency equipment such as the fire panel and alarms and some corridor lighting for approximately 7 hours as they were connected to a battery.

According to management staff, 9 residents who were outside of the home or not on their own home floor at the time of the outage became stranded on the main floor for approximately 8-9 hours. The home's 2 elevators were not functional at the time and could not be used to transport residents back to their rooms. All 9 residents were not able to use the stairs and the home did not have any alternative methods in which to transport them from floor to floor. Residents were therefore accommodated on mattresses which were placed on the floor within the dining room.

The home's cold holding equipment was not supplied with any back up power, however according to the food services supervisor, the temperature of the refrigerators did not rise high enough to affect perishable foods. None of the meals were affected and residents received their planned menu items.

The home's resident-staff communication and response system was not functional throughout the power outage (8-9 hours). No alternative system was in place other than more frequent monitoring of residents by staff.

Therapeutic air surfaces deflated and residents had to be transferred to foam mattresses. Many of the electric beds had to be manually modified.

The door locking system which operates on electricity and is on all stairwell and perimeter doors was not functional and had to be manually monitored by staff. [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 home's emergency plans do not provide for dealing with a loss of one or more essential services [as defined under s. 19(1)(a)(b) and (c)].

The home's emergency plans do not include information for staff regarding a loss of elevator service, resident-staff communication and response system, emergency lighting, safety and emergency equipment (i.e magnetic door locking system, fire alarm, fire panel) and life support equipment (i.e PEG tube feeding systems, oxygen, dialysis, therapeutic surfaces). The home's "loss of hydro" plan identifies some information regarding a loss of heat but it is not in keeping with s. 230(5) of Ontario Regulation 79/10. [s.230(4)1]

2. The home's emergency plans, specifically their "Loss of Hydro" plan does not address lines of authority, communications plan, and specific staff roles and responsibilities.

The "loss of hydro" plan, also identified as EPM I-10-10 dated April 1, 2013, lists tasks that need to be undertaken in the event of a loss of power, however the tasks have not been assigned to any specific staff member or their department. The plan does not include a line of authority which would identify who takes a lead role in decision making and does not specifically identify how the staff and residents in the building would be informed of any decisions or how orders would be communicated. [s.230(5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the emergency plans address the following components: Lines of Authority, Communications plan, Specific staff roles and responsibilities, to be implemented voluntarily.

Issued on this 28th day of August, 2013

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

B. Susnik

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2013_189120_0052
Log No. / Registre no:	H-000503-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 28, 2013
Licensee / Titulaire de permis :	RYKKA CARE CENTRES LP 50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6
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) (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.

Please email the plan to Bernadette.susnik@ontario.ca by October 14, 2013.

The plan shall be implemented within 6 months of the date of this Order.

Grounds / Motifs :

1. The home (classified as a C home) did not have guaranteed access to a generator that was operational within 3 hours of the power outage that affected the home between 6:15 p.m. on July 8, 2013 and 3:30 a.m. July 9, 2013 and that could maintain 1) the heating system 2) emergency lighting in hallways, corridors, stairways and exits, 3) essential services including dietary services equipment required to store food at safe temperatures and prepare and deliver meals and snacks, 4) the resident-staff communication and response system, 5) elevators, 6) life support and safety and emergency equipment.

The City of Mississauga, where the home is situated, was affected by a wide area power outage due to a storm beginning at approximately 5:30 p.m July 8, 2013. The home was without power to operate their heating system (if needed), dietary services equipment, resident-staff communication and response system, lighting, elevators, safety and emergency equipment and life support equipment. The home was able to operate some emergency equipment such as the fire

panel and alarms and some corridor lighting for approximately 7 hours as they were connected to a battery.

According to management staff, 9 residents who were outside of the home or not on their own home floor at the time of the outage became stranded on the main floor for approximately 8-9 hours. The home's 2 elevators were not functional at the time and could not be used to transport residents back to their rooms. All 9 residents were not able to use the stairs and the home did not have any alternative methods in which to transport them from floor to floor. Residents were therefore accommodated on mattresses which were placed on the floor within the dining room.

The home's cold holding equipment was not supplied with any back up power, however according to the food services supervisor, the temperature of the refrigerators did not rise high enough to affect perishable foods. None of the meals were affected and residents received their planned menu items.

The home's resident-staff communication and response system was not functional throughout the power outage (8-9 hours). No alternative system was in place other than more frequent monitoring of residents by staff.

Therapeutic air surfaces deflated and residents had to be transferred to foam mattresses. Many of the electric beds had to be manually modified.

The door locking system which operates on electricity and is on all stairwell and perimeter doors was not functional and had to be manually monitored by staff. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 14, 2013

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
Performance Improvement and Compliance 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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
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.

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

Ministère 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

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
Direction de l'amélioration de la performance et de la conformité
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 28th day of August, 2013

Signature of Inspector / Signature de l'inspecteur : B. Susnik

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

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