Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 17, 23, Jul 6, 2011	2011_054133_0002	Critical Incident

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9

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

PLEASANT MEADOW MANOR
99 Alma Street, P. O. Box 426, Norwood, ON, K0L-2V0

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator via telephone on June 22, 2011

During the course of the inspection, the inspector(s) reviewed the Critical Incident Report #2761-000005-11

The following Inspection Protocols were used in part or in whole during this inspection:
Critical Incident Response

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
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. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding.
2. An unexpected or sudden death, including a death resulting from an accident or suicide.
3. A resident who is missing for three hours or more.
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

s. 107. (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 79/10, s. 107 (2).

Findings/Faits sayants :

1. The home failed to notify the MOHLTC immediately about their loss of essential services on June 8, 2011 that occurred after normal business hours. The licensee did not make the report using the Ministry's method for after hours emergency contact.
2. On June 8, 2011 at 19:45 hr, the home lost hydro power. Hydro power was restored at 13:00 hr on June 9, 2011. The home was without hydro power for 17 hours.

The home first notified the MOHLTC of their loss of essential services via a telephone call to the MOHLTC Duty Inspector at 10:30 hr on June 9, 2011, which was 14 hours and 45 minutes after the loss of essential services.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 19. Generators

Specifically failed to comply with the following subsections:

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 sayants :

1. O. Reg 79/10, s. 19 (2) applies to this home because the home has beds that have been identified by the Ministry as structural category "B" beds.
2. As per O. Reg. 79/10, s. 19(4), section 19 (1)(a)(b)(c) are applicable as the home has Class B beds and therefore must have guaranteed access to a generator that will be operational within 3 hours of a power outage and that can maintain: (section 1(a)) the heating system, (section 1(b)) the emergency lighting in hallways, corridors, stairways and exits, and (section 1(c)) essential services, including 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, safety and emergency equipment.

On June 8, 2011 at 19:45 hr, the home lost hydro power. Hydro power was restored June 9, 2011 at 13:00hr. The home was without hydro power for 17 hours.

On June 9, 2011, the home notified the MOHLTC via a telephone call that they do not have a generator on site and did not have an operational generator within 3 hours of the power outage.

The home submitted a Critical Incident report (#2761-000005-11) to the MOHLTC on June 10, 2011 confirming that the home has no generator and did not have an operational generator within 3 hours of the power outage.

Telephone call held on June 22, 2011 with Administrator Sandra Tucker confirmed that the home has no generator and did not have an operational generator within 3 hours of the power outage. The Administrator indicated to the inspector that the home does have a contract with a local hardware store that gives the home "first option" for use of a small domestic style generator which she believes could power one of the home's refrigerators or a freezer. The home chose not to bring in the generator because they had a contingency plan in place for storing their food at safe temperatures. On the Critical Incident report submitted by the home it is noted that "several refrigerated items had to be discarded due to high food temperatures (dairy products, eggs and salad dressings).

Issued on this 11th day of July, 2011

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

Jessica Lapensée