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

Ottawa Service Area Office
347 Preston St 4th Floor
OTTAWA ON L1K 0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston 4iém étage
OTTAWA ON L1K 0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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
Dec 3, 2014	2014_346133_0013	O-000935-14	Complaint

Licensee/Titulaire de permis

TAMINAGI INC.
05 Loiselle Street CP Box 2132 Embrun ON K0A 1W1

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

SARSFIELD COLONIAL HOME
2861 Colonial Road P.O. Box 130 Sarsfield ON K0A 3E0

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 Complaint inspection.

This inspection was conducted on the following date(s): October 28th and 29th, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Assistant Director of Care, the Environmental Manager, registered and non registered nursing staff.

During the course of the inspection, the inspector reviewed the licensee's emergency plan related to the loss of elevator service, reviewed documentation related to the maintenance of the home's elevator, reviewed nursing communication book entries from August 2014 and September 2014, reviewed the plan of care for several residents, reviewed the nursing shift report for September 14th - 15th, 2014.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 107 (3) 2. iii in that the licensee failed to inform the Director of a loss of an essential service that affected the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours within one business day after the occurrence of the incident, followed by a report required under subsection (4). This is specifically related to the home's one elevator, which was unavailable for use August 31st - September 2nd,

2014, and on September 14th, 2014.

As per O. Reg. 79/10, s. 19 (1) c., an elevator is defined as an essential service.

Sarsfield Colonial Home is a 46 bed home. There are resident bedrooms on the 1st - 3rd floors. The home's main exit/entrance is on the main level. The home's dining room is on the basement level. The elevator services the basement level, and 1st-3rd floors. There is a ramp and stairs between the main level and the basement level, and stairs from the main level to the 1st -3rd levels.

In discussion with the home's Administrator and Environmental Manager (EM) over the course of the complaint inspection (October 28th, 29th, 2014), Inspector #133 was made aware that there is a problem with the elevator that is recognized and which occurs intermittently. That is, when the elevator service buttons are pressed, the elevator will not respond to the call for service and remain in the basement level. It may also occur that the elevator goes up and down but the doors won't open. This is said to occur with no distinct frequency. The EM stated that this it could occur once a month, once every few months, or more, or less. It was acknowledged by the EM that there were more elevator problems than usual in September 2014. The EM explained that when this problem occurs, if he is not present, registered nursing staff are asked to go into the maintenance room, access the breaker panel that houses the elevator breaker, and then flip the elevator breaker switch to the "off" position, then back to the "on" position. The EM explained that this process is an attempt to reset the elevator. If the elevator does not respond to a call for service after this intervention, the EM contacts the home's elevator repair and maintenance provider.

The Administrator explained to the Inspector that the solution to this intermittent problem is replacement of the elevator control system, for which the home has a current quote. The Administrator stated that so far, the home's elevator repair and maintenance provider has been able to find replacement parts for the control system when they are needed. The elevator control system is original to the building, which the Administrator confirmed was built in 1970. The elevator cylinder was replaced in 2009.

The elevator control system is the system responsible for coordinating all aspects of elevator service such as travel, speed, and accelerating, decelerating, door opening speed and delay, leveling and hall lantern signals. It accepts inputs (e.g. button signals) and produces outputs (elevator cars moving, doors opening, etc.).

The following details elevator service interruptions that the Inspector was made aware of during the inspection, conducted on October 28th and 29th, 2014.

A) The home's elevator was not available for use between August 31st, 2014, at approximately 9:30pm, and September 2nd, 2014, at approximately 11am.

The EM explained to the Inspector that on August 31st, 2014, he was called around 9:30pm and was told that the home's elevator was not working. The elevator was not responding to calls for service when staff pushed the up or down buttons from the care units. The EM was unable to go to the home, and the registered nurse working that night was not familiar with the reset process, so the EM called the home's elevator repair and maintenance provider to request service.

Registered nurse #S101 worked the day shift on September 1st and 2nd, 2014. On October 29th, 2014, staff #S101 explained the following to the Inspector, related to the elevator service interruption:

i) When they arrived for their shift at 6am, on September 1st, 2014, the home's elevator was now moving between floors. The elevator doors would, however, not open. The elevator technician first arrived around 9am, and following a few hours of work, declared the elevator to be repaired. Staff #S101, the elevator technician, and resident #001 then went down to the basement level, together, in the elevator. It went below grade, 4-6 inches lower than it should have gone, and the technician indicated to staff #S101 that he did not currently have the means to fix the problem. The elevator was left out of service. The technician then left the home in order to respond to an emergency call for service elsewhere.

Following a description of corrective actions taken in response to the service call, the technician's note from September 1st, 2014 reads "ran am. ok, then intermittent, going on slow speed and stopping off level, left off for further repairs".

ii) An elevator technician returned to the home on September 2nd, 2014, and it was repaired in time to allow for the lunch meal to be served in the dining room.

iii) All residents ate breakfast, lunch and dinner on their respective units on September 1st, and all residents ate breakfast on their respective units on September 2nd, due to the elevator service disruption. A modified menu was served in the unit activity rooms.

iv) One resident's family, resident #002 had to be made aware that they couldn't come and pick up their family member for an outing as the elevator was not available for their use during this time.

v) The dental service provider's visit to the home on September 2nd, 2014, was cancelled due to the elevator outage.

B). The home's elevator was not available for use, for a 6.5 – 8.5 hour period, on September 14th, 2014.

Personal Support Workers #S102 and #S103 were working the day shift on September 14th, 2014. On October 29th, 2014, the Inspector spoke with both of them about the elevator service interruption that had occurred. Staff #S102 and #S103 explained to the Inspector that the elevator had first stopped working on September 14th, 2014, following the second seating of breakfast. The elevator would not respond to calls for service when the up or down buttons were pressed. Nursing staff were in the process of portering residents back to their care units from the basement dining room at the time. Staff #S102 and #S103 explained that the Environmental Manager (EM) was contacted, and that he was able to reset the elevator once on-site. All residents who remained in the basement were then brought back to their care units in the elevator. Staff #S102 and #S103 explained that the elevator stopped working again at approximately 1:30pm. Nursing staff had just begun portering residents back to their care units, following the second seating of lunch. The EM was called back to the home and tried to reset the elevator, but this time it did not work. The home's elevator repair and maintenance provider was called for assistance.

Of the residents who remained in the dining room, the majority were brought back to their respective care units by the EM, before the elevator was repaired. The EM brought 13-15 residents up the stairs with a stair climber device. This process occurred throughout the afternoon. The home purchased this device in 2009, when the elevator was out of service for 6 weeks, due to cylinder replacement. It can be used to transport one person at a time, up or down the stairs if needed.

The elevator service interruption prevented nursing staff from putting affected residents to bed that would normally want/need to do so after lunch. A note from the home's nursing communication book, made by day shift (6am – 2pm) staff, on September 14th, 2014 reads "sorry no one is in bed, elevator not working".

Four residents, #003 - #006, were not brought back up to their respective care units with the stair climber device. The EM explained that he felt it would be better to wait until the elevator was repaired, as opposed to using the stair climber device, for these particular residents. The EM explained that he believed the elevator would be repaired sooner than it was.

A modified dinner menu was served in the care unit activity rooms. The four residents (#003 - #006) who were not brought back up to their care units by the EM had their dinner in the dining room. These four were returned to their care units once the elevator was repaired, sometime between 8pm-10pm that night.

As per discussion with the home's Assistant Director of Care (ADOC), on October 29th, 2014, resident #003 - #006 are dependent on nursing staff for all aspects of their personal care, including continence care. All four identified residents are mobilized with wheelchairs.

Registered nurse, staff #104, worked the evening shift on September 14th, 2014. On October 29th, 2014, they told the Inspector that all nursing staff working that evening were tasked with taking turns to check on resident #003 - #006. As well, staff # S104 noted that resident #004's spouse was with them for much of the time they were in the dining room. Staff # 104 confirmed that all four residents remained in their wheelchairs for the duration of their time in the dining room. Staff #104 told the Inspector that nursing staff were checking the resident's continence briefs while they were seated in their wheelchairs, and that the EM would have carried a mechanical lift down to the basement if it had been needed, to allow nursing staff to change a resident's continence brief.

Related to resident #004s care needs, on October 29th, 2014, the home's ADOC explained to the Inspector that the resident always goes to bed after lunch. This is due to a medical condition, and resident #004 is on a schedule of bed rest, in an effort to heal the condition. The ADOC explained that resident #004 only gets up out of bed for meals, and is to stay upright after meals only long enough to allow for digestion, about 30 minutes.

Related to resident #005's care needs, on October 29th, 2014, the home's ADOC explained to the Inspector that the resident always goes to bed after lunch. This is in part due to a medical condition.

The licensee failed to notify the Director about the loss of an essential service,

specifically related to the home's only elevator, that occurred for a period of greater than 6 hours on two occasions in September 2014, and which affected the provision of care or the safety, security or well-being of one or more residents. [s. 107. (3)]

2. The licensee has failed to comply with O. Reg. 79/10, s. 107 (4) in that the licensee failed to make a report in writing to the Director, within 10 days of becoming aware of an environmental hazard that affected the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours. This is specifically related to the home's one elevator, which was unavailable for use August 31st-September 2nd, and on September 14th, 2014. As per O. Reg. 79/10, s. 19 (1) c., an elevator is defined as an essential service.

As a result of this complaint investigation, related to the home's elevator, it was ascertained that the licensee failed to inform the Director in any way, about two periods of time when the elevator was unavailable for use for more than 6 hours, in September 2014. [s. 107. (4) 1.]

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 with the requirement to inform the Director within one business day of a loss of elevator service that occurs for a period of greater than 6 hours, and then to make a report in writing to the Director within 10 days, which includes all of the required information, to be implemented voluntarily.

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. (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 has failed to comply with O. Reg. 79/10, s. 230 (5) 1. and (5) 3. in that the licensee's written emergency plan that provides with dealing with the malfunction of the home's elevator does not address plan activation or a communication plan.

As per O. Reg. 79/10, s. 230 (2) and O. Reg. 79/10, s. 230 (4) 1. viii, the licensee must have a written emergency plan that provides for dealing with the loss of one or more essential services.

As per O. Reg. 79/10, s. 19 (1) c., elevators are defined as an essential service.

The Inspector obtained a copy of the licensee's written emergency plan that provides with dealing with the malfunction of the home's elevator on October 29th, 2014. The plan is titled "elevator malfunction", with an effective date of December 2009, and most current review date of July 16th, 2013.

The emergency plan, as noted above, does not address plan activation. The plan states "Should the elevator be set out of service for a prolonged period of time, determined by KONE, the administrator needs to assess the situation and contact the Ministry of Health". This statement does not quantify when the plan will be activated. As well, this statement does not reflect the need to contact the Ministry of Health, by way of notification to the Director, within one business day, if the elevator has been out of service for 6 hours or more, as required by O. Reg. 79/10, s. 107 (3). There is no other statement related to the notion of plan activation within the plan.

The emergency plan, as noted above, does not address a communication plan. The plan states "communication to all concerned, employees, family members, services, residents….needs to be done as soon as possible by notices, newsletters, memos……". While this statement reflects the need to communicate about an elevator malfunction, it does not outline an actual communication plan. [s. 230. (5)]

Issued on this 3rd day of December, 2014

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

Original report signed by the inspector.