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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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
Feb 5, 2016	2016_346133_0001	O-002185-15	Follow up

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 Follow up inspection.

This inspection was conducted on the following date(s): January 15th, 2016

This inspection was in follow up to a compliance order related to the emergency plans that provide for dealing with the loss of elevator service.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Environmental Manager, the Activity Director and the Office Manager.

The inspector reviewed written emergency procedures related to the loss of elevator service as provided by the Office Manager, the Director of Care, the Activity Director and the Environmental Manager.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 87. Emergency plans

Specifically failed to comply with the following:

s. 87. (1) Every licensee of a long-term care home shall ensure that there are emergency plans in place for the home that comply with the regulations, including,
(a) measures for dealing with emergencies; and 2007, c. 8, s. 87. (1).
(b) procedures for evacuating and relocating the residents, and evacuating staff and others in case of an emergency. 2007, c. 8, s. 87. (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s.87 in that the licensee has failed to ensure that there are emergency plans in place for the home that comply with the regulations.

This is the licensee's second consecutive finding of non-compliance that includes a compliance order and third consecutive finding of non-compliance, related to the emergency plans that provide for the loss of elevator service. As a result of inspection #2014_346133_0013, conducted in October 2014 by inspector #133, a written notification with the additional required action of a voluntary plan of correction was issued. As a result of inspection #2015_346133_0007, conducted in March 2015, the licensee was served with a compliance order. The compliance date for the order was originally set at July 27th, 2015, and then upon request from the licensee, the compliance date was extended to September 30, 2015. The compliance order required that the licensee ensure that the emergency plan for the home that provides for dealing with the recurring short term loss of elevator service was in writing; ensure that the emergency plans relating to loss of elevator service in general addressed the following components: plan activation, line of authority, communications plan, specific staff roles and responsibilities; and, ensure that the plans are evaluated and updated at least annually.

It has been previously established (inspection #2014_346133_0013 and #2015_346133_0007) by inspector #133 that there has been periods of recurrent short term loss of elevator service at the home. With the exception of the elevator cylinder, the elevator dates from 1964. Given the design of the home, the loss of elevator service, particularly when residents are in the basement dining room, has potential to negatively impact on the comfort of residents and the provision of care to the residents.

In accordance with O. Reg. 79/10, s.230 (2), the licensee shall ensure that the emergency plans for the home are in writing.

In accordance with O. Reg. 79/10, s. 230 (4) 1. viii. the licensee shall ensure that the emergency plans provide for the loss of essential services. Essential services, as outlined in O. Reg. 79/10, s. 19 (1) (c), include elevators.

In accordance with O. Reg. 79/10, s. 230 (5), the licensee shall ensure that the emergency plans address four specified components: plan activation, lines of authority, communications plan, specific staff roles and responsibilities.

On January 15th, 2016, inspector #133 conducted a follow up inspection at the home.

Upon arrival, the inspector was informed by the office manager that the Administrator was not present and was not available for discussion. The office manager informed that she had been given emergency procedures related to elevator malfunction by the Director of Care (DOC), the Activity Director and the Dietary Manager to amalgamate. The office manager provided the inspector with a seven page document entitled "elevator malfunction nursing department", effective date November 2015, Authorized by: "DOC, Activity and Dietary Depts". The office manager indicated this amalgamated document had been provided to the Administrator for final review and approval, and she was not aware if that had occured. The office manager indicated to the inspector that she believed that the home's Environmental Manager (EM) had information that needed to be added to the document. The inspector met with the EM and he provided a handwritten, double sided, plan titled "elevator breakdown". As well, the EM explained that he meant to include an excerpt from the home's previous elevator malfunction emergency procedure, effective date December 2009. The EM photocopied page 2 of 3 of that procedure and indicated the parts that spoke to the role of the environmental manager were to be included with his current handwritten plan. The inspector met with the DOC, who advised that she had produced contingency plans, referenced within the amalgamated document but not included, and she provided the three paged (two double sided and one single page) "contingency plan for outage of elevator" to the inspector. The inspector met with the Activity Director, who explained that she had also produced a written routine for the physiotherapy assistant in the event of an elevator outage, which had not been included in the amalgamated document. The one page document, "physiotherapy assistant routine elevator outage", approved by administrator, dated 07/13/15 was then provided to the inspector.

On January 29th, 2016, the inspector spoke with the Administrator, who is also the licensee, on the phone. The Administrator indicated that she believed that all managers had done the work that was required in terms of writing emergency plans for the loss of elevator service. The Administrator indicated that she had not reviewed all of the information collected by the inspector. The Administrator confirmed she had no additional information to provide to the inspector at that time.

Considering the various pieces of information given to the inspector, it is concluded that the emergency plan for dealing with the short term loss of elevator service is not all in writing. For example, while the home has a stair climber device that can be used to bring residents back to their care units from the basement dining room, the process is slow as it can only accommodate one resident at a time, and not all residents can fit in the stair climber. In the past (see inspection #2014_346133_0013), this has resulted in some

residents being left in the dining room for a period of 6.5 – 8.5 hours. Inspector #133 had been told that nursing staff had been redeployed so as to ensure resident supervision during that time. On January 12th, 2016, the DOC confirmed to the inspector that if residents had to be left in the dining room again due to an elevator outage, nursing staff would be required to supervise the residents, at a frequency that met the resident's needs, from 15 minute checks to continuous supervision. This aspect of the plan was not in writing. As well, the plan related to how residents who cannot fit in the stair climber would be returned to their units if there were an extended elevator outage, or their care needs required it, such as those who are on bed rest with the exception of meal times, was not in writing.

Considering the various pieces of information given to the inspector, it is concluded that the emergency plan for dealing with the loss of elevator service does not address a communication plan. Within the nursing contingency plan for outage of elevator, in the "general" section at the end, it is written that "family members/POA will be notified with a newsletter sent by mail/email that will explained the present situation and reassure them that the level of care and safety of their loveone will be maintained". There is no specified staff person/position designated for this role. As per discussion with the DOC during the inspection, not all family members/POAs have email, and a newsletter sent in the mail does not serve as a communication plan for notification of a short term loss of elevator usage. Also within the nursing contingency plan for outage of elevator, in the section that refers to transportation of medication carts, on the back of the second page, it is written that "classic care will be notified immediately so can assist us with medication distribution". There is no specified staff person/position designated for this role. As well, in the past (see inspection #2014_346133_0013), service providers, such as the dental service provider, had to be cancelled due to an outage of elevator service which spanned August 31st – September 2nd, 2014. For the same reason, related to the same inspection, a visitor had to be notified that they could not come to take a resident out for an outing as the stair climber was not an option. Each day at the home, there may be specific activities, services and visitors scheduled that rely on elevator service, many of which are known to the home in advance. In general, there is not an overall communication plan in place to ensure notification of short term loss of elevator service to all necessary parties.

Considering the various pieces of information given to the inspector, it is concluded that the emergency plans for the home that provide for dealing with the loss of elevator service do not address lines of authority. There are references made to what the various managers and staff persons will do, who is to inform who of what, but overall, lines of

authority are not identified or stated. For example, the EM's plan includes the following statement "after updated arrival time with KONE elevator. Person in charge have to decide if we wait until elevator mechanic is done to put elevator is back on service or if delay too long start "stair climber" procedure". The EM's plan does elaborate as to who the person in charge is. Clear lines of authority are required to ensure effective plan activation and implementation across all departments. It is acknowledged that lines of authority may differ, depending on the timing of an emergency, and who is available at the time of an emergency. Given the size of the home, for example, it is not unusual that the Administrator, Director of Care and Dietary Manager are not present on the same day.

The ongoing non-compliance related to emergency plans that provide for dealing with the loss of elevator service presents as a potential risk to residents in the event of a loss of elevator service. [s. 87. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 5th day of February, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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) :	JESSICA LAPENSEE (133)
Inspection No. / No de l'inspection :	2016_346133_0001
Log No. / Registre no:	O-002185-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Feb 5, 2016
Licensee / Titulaire de permis :	TAMINAGI INC. 05 Loiselle Street, CP Box 2132, Embrun, ON, K0A-1W1
LTC Home / Foyer de SLD :	SARSFIELD COLONIAL HOME 2861 Colonial Road, P.O. Box 130, Sarsfield, ON, K0A-3E0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CHANTAL CRISPIN

To TAMINAGI INC., 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: 2015_346133_0007, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 87. (1) Every licensee of a long-term care home shall ensure that there are emergency plans in place for the home that comply with the regulations, including,
(a) measures for dealing with emergencies; and
(b) procedures for evacuating and relocating the residents, and evacuating staff and others in case of an emergency. 2007, c. 8, s. 87. (1).

Order / Ordre :

In order to ensure that there are emergency plans in place for the home that comply with the regulations, the licensee will:

a) Amalgamate emergency planning information relating to loss of elevator service from all departments in order to create one comprehensive plan or create stand-alone plans for each department.

b) Ensure that all aspects of the plan in place for dealing with the loss of elevator service is in writing, including how residents who may be left in the dining room due to loss of elevator service would be supervised by staff to ensure their care and safety and how such residents, who may not be able to fit in the stair climber, would be returned to their care units if and when needed.

c) Ensure that the one comprehensive plan or the individual departmental plans clearly address the following components: plan activation, lines of authority, communications plan, specific staff roles and responsibilities.

d) Related to communications plan and specific staff roles and responsibilities, ensure that there are persons/a person specifically designated to conduct communications referenced within the plan(s), and that there is a plan that will ensure timely communication to all necessary parties in the event of a loss of elevator service.

e) Related to lines of authority, ensure the plan(s) outline clear lines of authority to ensure effective plan activation and implementation across all departments.

f) Ensure that when a specific manager is designate with responsibility, the plan also provides for the possibility that the manager is not available. For example, on weekends, evenings and nights, or when a manager is not working during a day of the week.

The Administrator will ensure that on the compliance date, March 31st, 2016, the final version of the plan(s) are available at the home and accessible to all concerned parties, regardless of if the Administrator is present or not, should an emergency occur.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s.87 in that the licensee has failed to ensure that there are emergency plans in place for

the home that comply with the regulations.

This is the licensee's second consecutive finding of non-compliance that includes a compliance order and third consecutive finding of non-compliance, related to the emergency plans that provide for the loss of elevator service. As a result of inspection #2014_346133_0013, conducted in October 2014 by inspector #133, a written notification with the additional required action of a voluntary plan of correction was issued. As a result of inspection #2015_346133_0007, conducted in March 2015, the licensee was served with a compliance order. The compliance date for the order was originally set at July 27th, 2015, and then upon request from the licensee, the compliance date was extended to September 30, 2015. The compliance order required that the licensee ensure that the emergency plan for the home that provides for dealing with the recurring short term loss of elevator service was in writing; ensure that the emergency plans relating to loss of elevator service in general addressed the following components: plan activation, line of authority, communications plan, specific staff roles and responsibilities; and, ensure that the plans are evaluated and updated at least annually.

It has been previously established (inspection #2014_346133_0013 and #2015_346133_0007) by inspector #133 that there has been periods of recurrent short term loss of elevator service at the home. With the exception of the elevator cylinder, the elevator dates from 1964. Given the design of the home, the loss of elevator service, particularly when residents are in the basement dining room, has potential to negatively impact on the comfort of residents and the provision of care to the residents.

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the basement dining room, the process is slow as it can only accommodate one resident at a time, and not all residents can fit in the stair climber. In the past (see inspection #2014_346133_0013), this has resulted in some residents being left in the dining room for a period of 6.5 – 8.5 hours. Inspector #133 had been told that nursing staff had been redeployed so as to ensure resident supervision during that time. On January 12th, 2016, the DOC confirmed to the inspector that if residents had to be left in the dining room again due to an elevator outage, nursing staff would be required to supervise the residents, at a frequency that met the resident's needs, from 15 minute checks to continuous supervision. This aspect of the plan was not in writing. As well, the plan related to how residents who cannot fit in the stair climber would be returned to their units if there were an extended elevator outage, or their care needs required it, such as those who are on bed rest with the exception of meal times, was not in writing.

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The ongoing non-compliance related to emergency plans that provide for dealing with the loss of elevator service presents as a potential risk to residents in the event of a loss of elevator service. (133)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
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.

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 5th day of February, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JESSICA LAPENSEE

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