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

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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
Oct 27, 2014	2014_189120_0066	T-223/460/1124-14	Complaint

Licensee/Titulaire de permis

DON MILLS FOUNDATION FOR SENIORS
1 Overland Drive, TORONTO, ON, M3C-2C3

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

THOMPSON HOUSE
1 OVERLAND DRIVE, NORTH YORK, ON, M3C-2C3

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 Complaint inspection.

This inspection was conducted on the following date(s): October 15 & 16, 2014

The visit related to the investigation of a critical incident submitted by the home on January 6, 2014 related to a power outage and two separate complaints, one related to the failure to provide essential services during a power outage on December 22, 2013 and the other related to the lack of functioning elevators between June 30 and October 4, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, Clinical Co-ordinator, Food Services Supervisor, Environmental Services Supervisor, registered staff, personal support workers and maintenance staff.

During the course of the inspection, the inspector(s) toured the home, measured illumination (light) levels, reviewed the home's emergency plans, tested the resident-staff communication and response system, tested door access control systems, reviewed the home's cleaning and disinfection routines for personal care articles and evaluated safety risks.

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 VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee did not ensure that all doors leading to stairways were,

ii. equipped with a door access control system, and
iii. equipped with an audible door alarm that allowed the call to be canceled only at the point of activation (at the door), and
A. that the stairwell doors were connected to the resident-staff communication and response system, or
B. was connected to an audio visual enunciator that was connected to the nurses' station nearest to the door and had a manual reset switch at each door.

Three stairwell doors were located on each of the 4 floors within the home and 2 sets of main entrance doors were available on the 2nd floor. One stairwell door (zone 21) located in the lowest level of the building was not equipped with a door access control system, allowing residents access to the stairwell from the corridor leading to the dining room and hair salon. The other 2 stairwell doors were inaccessible to the residents. The stairwell doors and the 2 main entrance doors did not alarm when tested (held open for more than 1 minute). The individual enunciator panels which were identified on floors 2-4 did not have a visual indicator installed for the various doors to alert staff as to the location of breached or disengaged door. [s. 9(1)]

2. The licensee did not ensure that all doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, were equipped with locks to restrict unsupervised access to those areas by residents.

One door leading to an enclosed terrace located on the 2nd floor was not locked when tested and could not be locked. The door was not a designated fire exit. Instead, the door was equipped with an alarm and key pad. The alarm was engaged at the time of the test, however the sound was wired to an enunciator panel on the 4th floor. Twenty minutes later, when visiting with staff on the 4th floor, the registered nurse had just identified that the enunciator panel was indicting both a visual and audio alert that the door to the terrace had been opened and called staff on the 2nd floor to check it. Up to that point, no staff had gone to check the door. The audio alert was not very audible unless a staff member was standing near the enunciator panel. The slow response to the alarm was of particular concern and would have been a serious risk if a confused resident exited during a cold winter day. A locking mechanism is therefore required on the terrace door which could be managed by staff for certain times of the day and year.
[s. 9(1)1.1]

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. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee did not ensure that activation stations connected to the resident-staff communication and response system were made available in every area accessible by residents. The first floor dining room, hair salon and recreation room, 2nd floor lounges, activity room, solarium, family room, library and outdoor terrace, 3rd floor lounges, 4th floor dining/activity rooms, lounges and snoozelen room were not equipped with activation stations to trigger a visual and audio response to alert staff. [s. 17(1)(e)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee did not ensure that the lighting requirements as set out in the lighting table were maintained.

The home was built in 1969 and therefore the section of the lighting table that applies is titled "All Other Homes". Measurements were taken of the light fixtures in specific areas throughout the home using a hand held analog illumination meter. One bedroom and one resident ensuite washroom that represented all of the resident

washrooms and bedrooms were tested. Each tub/shower room, the 4th floor corridors, common washrooms, various dining rooms and all sitting areas were tested. Natural light was filtered out as much as possible (blinds/curtains pulled) to mimic night time conditions when lighting levels drop and depend on an artificial source. The meter was held level at a standard 30 inches above the floor, out away from the body and towards sources of artificial light. The outdoor condition on the day of the test was overcast. Only those areas that did not comply are listed below.

Resident Bedrooms

Second and 3rd floor bedrooms were equipped with a hanging globe-shaped light fixture with opaque glass in the centre of the room. In room #231, the lux under the light was 20. In room #229, the lux was 100. The type of bulb supplied was different in the two rooms tested. Each room was also equipped with a vanity and sink area outside of an ensuite washroom. This area was 300 lux in room #323 and 170 lux in room #231.

Resident rooms on the 4th floor were not equipped with any general room light fixtures. Room #437 was 0 lux at the foot of the bed and around the wardrobe area.

An over bed light was provided in all bedrooms, some with a wood valence and those on the fourth floor with a metal valence. In room #231, the over bed lux was adequate at 400. In room #437, the over bed light was 200 lux at the reading position over the bed and dropped to 20 lux when the meter was held near the side and foot of the bed.

The bedrooms are required to have 215.28 lux in and around the bed, wardrobes and other areas where residents would dress, sit or perform activities. The required lux for the over bed light is 376.73.

Washrooms

The resident ensuite washrooms were equipped with a large round flush mounted wall sconce which was 10 lux in #231 and 50 lux in other random washrooms. A common washroom on the 2nd floor was 200 lux at the vanity and toilet. A minimum lux of 215.28 is required in and around the vanity and toilet areas.

Tub/Shower Rooms

Shower rooms were equipped with different types of light fixtures. Those with fluorescent tube lighting were adequate, others with wall mounted fixtures and flush mounted ceiling fixtures were not adequate and did not achieve the required 215.28 lux.

2nd floor tub - 90-120 lux
3rd floor N shower - 75 lux
4th floor W tub - 10 lux (one light burnt out)

Corridors

Floors 2-4 were equipped with fluorescent tube light fixtures with a metal lens hung on the walls approximately 6 feet above the floor level. The lux levels were above 215.28 lux for the majority of the length of the corridors except for those areas where there were access points to soiled utility rooms, tub and shower rooms and storage closets.

The area in front of the large elevator on the first floor (lowest level) was equipped with 6 pot lights spaced 7 feet apart. The lux level under and between the lights was 20-50 lux.

The corridor on the first floor that runs along side the dining room and towards and past the hair salon was equipped with pot lights and tube lights on the wall behind a valence. The lux was 50-150 lux.

All corridors are required to provide a minimum of 215.28 lux that is consistent and continuous along the length of the corridor.

Dining areas

The dining rooms on all of the floors except the first floor had sufficient lighting levels. The dining room on the first floor was equipped with chandeliers, wall sconces, fluorescent tube lights and track lights. Areas with the chandeliers were inadequate with values between 20 to 150 lux. The measurements were taken directly over the dining tables (table #3-40 lux, table #4-50 lux, table #19-20 lux, table #16-150 lux).

The area with the track lighting was a walking area which was 38 feet in length. Only 7 pot lights were provided for a general lux of 100 along the length of the corridor. The minimum requirement is 215.28 lux in and around table areas and walking areas.

Activity Room

The activity space on the 2nd floor with the sink and counter had a large activity table in the centre of the room. The area around the table was 170 lux instead of the required 215.28 lux. [s. 18]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 10. Elevators
Specifically failed to comply with the following:

s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Findings/Faits saillants :

1. The licensee did not ensure that any elevators in the home were equipped to restrict resident access to areas that were not to be accessed by residents.

Two elevators were located in the home for resident use. Both elevators were heavily used by residents and staff to gain access to a dining area and hair salon located on the lowest level in the home. However, the smaller elevator was of concern as it exited into a service area near a set of delivery doors and a kitchen. Residents exiting from the elevator were required to travel a short distance to a door dividing the service area and the dining room. The door was equipped with a locking mechanism. According to the Administrator, the service area door was recently equipped with a locking mechanism to restrict resident access into the service area, yet the elevator was not equally equipped with a restrictive device or mechanism.

At the time of the review and for several hours thereafter, the delivery doors remained unsecured and could have been used by any resident to exit the building without staff knowledge. [s. 10(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 to ensure that the small service elevator in the home is equipped to restrict resident access to areas that are not to be accessed by residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).
(c) removal and safe disposal of dry and wet garbage; and O. Reg. 79/10, s. 87 (2).
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee did not ensure that procedures were developed and implemented for cleaning and disinfecting resident care equipment and that a low level disinfectant was used in accordance with manufacturer's instructions on resident care equipment between use.

During the tour of all of the tub and shower rooms on October 15, 2014, it was identified that staff did not have available to them the appropriate disinfecting product and cleaning implements for either the tubs or the shower chairs. When discussions were held with resident care staff regarding the tubs, they stated that residents were not bathed, only showered. A review was made of the home's infection prevention and control policies and no policies had been developed with respect to tub cleaning protocols should a resident wish to be bathed.

For the shower chairs, a policy titled "Cleaning & Disinfecting of shower/Tub areas, Bedpans, commodes Urinals - IC-0503-00" dated January 2014 was reviewed. The procedure within the policy did not identify how the shower chairs were to be cleaned prior to disinfection. The procedure stated to use a disinfectant and to "leave the disinfectant on for at least 5 minutes then rinse off". Another policy identified as "IC-0902-01" required staff to clean the resident care equipment first with friction before being disinfected but did not specify how the friction would be applied (cloth or brush etc).

Each shower room was toured and a spray bottle containing a green substance labeled "cleaner" found stored within the rooms. Confirmation was made with the Clinical Co-ordinator who was also the Infection Control Designate that the product was in fact being directed for use on shower chairs. She was not able to identify the availability of a disinfectant or how surfaces (especially if visibly soiled) were cleaned with friction before disinfection. The home's maintenance person identified himself as being the person who provided staff with the green solution but clarified that it was only to be used on walls and the floor, not shower chairs. He stated that he was waiting to introduce a specified disinfectant product but was waiting on labels to arrive for the bottles.

The Director of Care was not available at the time of inspection and the confusion between policies and the use of the green cleaning solution was discussed with the Administrator on October 16, 2014. [s. 87(2)]

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 procedures are developed and implemented for the cleaning and disinfection of all resident care equipment and that a low level disinfectant is used on resident care equipment as per manufacturer's instructions, to be implemented voluntarily.

WN #6: 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):

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).

This section has been deleted from the report. BS Dec 9/14

Findings/Faits saillants :

1. The licensee did not ensure that the Director was informed no later than one business day after the occurrence of a loss of essential services that lasted for a period greater than 6 hours. A loss of power was experienced by the home that began on December 22, 2013 at approximately 8 a.m. and ended on December 24, 2013 at approximately 1:00 p.m. The Director was not informed of the incident until January 6, 2014. [s. 107(3)2]

BS

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 Director is informed no later than one business day after the occurrence of a loss of essential services that lasts for a period lasting more than 6 hours, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (3) In developing the plans, the licensee shall,
(a) consult with the relevant community agencies, partner facilities and resources that will be involved in responding to the emergency; and O. Reg. 79/10, s. 230 (3).
(b) ensure that hazards and risks that may give rise to an emergency impacting the home are identified and assessed, whether the hazards and risks arise within the home or in the surrounding vicinity or community. O. Reg. 79/10, s. 230 (3).

s. 230. (4) The licensee shall ensure that the emergency plans provide for the following:
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).

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).

s. 230. (6) The licensee shall ensure that the emergency plans for the home are evaluated and updated at least annually, including the updating of all emergency contact information. O. Reg. 79/10, s. 230 (6).

s. 230. (7) The licensee shall,
(a) test the emergency plans related to the loss of essential services, fires, situations involving a missing resident, medical emergencies and violent outbursts on an annual basis, including the arrangements with the community agencies, partner facilities and resources that will be involved in responding to an emergency; O. Reg. 79/10, s. 230 (7).
(b) test all other emergency plans at least once every three years, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency; O. Reg. 79/10, s. 230 (7).
(c) conduct a planned evacuation at least once every three years; and O. Reg. 79/10, s. 230 (7).
(d) keep a written record of the testing of the emergency plans and planned evacuation and of the changes made to improve the plans. O. Reg. 79/10, s. 230 (7).

Findings/Faits saillants :

1. The licensee did not ensure that in developing their emergency plans (exluding fire), that they consulted with relevant community agencies, partner facilities and resources that would be involved in responding to the emergency. [s. 230(3)]

2. The licensee did not ensure that their emergency plans (exluding fire) identified which community agency, partner facility and resource would be involved in responding to the emergency. [s. 230(4)4]

3. The licensee did not ensure that their emergency plans (exluding fire) addressed the following components:

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

A review of the home's "Interruption of Services - EM03-002" policy and procedure did not provide adequate information for staff response. The policy did not identify exactly when the plan would be activated. The lines of authority were not identified. It simply stated that the Control Officer would be directing staff and visitors. The plan did not identify how directives to staff, residents and visitors would be communicated. Specific staff roles and responsibilities for all departments involved in the emergency were not identified. Staff responsibilities only included "comfort of residents and to not

leave the premises unless relieved by the Control Officer". No specific tasks were assigned to various staff members of the home other than the Control Officer. The officer's responsibilities were listed but they were limited. Other emergency plans were also reviewed and were written without the basic components. [s. 230(5)]

4. The licensee did not ensure that their emergency plans for the home were evaluated and updated annually. The emergency plans that were provided for review during the inspection were dated December 2006 and the Administrator confirmed that they had not been reviewed since he has been the Administrator of the home (over three years). [s. 230. (6)]

5. The licensee, according to the Administrator, did not test their emergency plans related to a loss of essential services on an annual basis, did not test all other emergency plans at least once every three years and did not conduct an evacuation at least once every three years.

Essential services include lighting, heating, electricity, elevators, door security system, food preparation and temperature holding equipment, the resident-staff communication and response system and emergency equipment (fire panel etc) and these types of emergencies were not tested annually.

Other emergency plans related to bomb threats, chemical spills, community disasters (weather related events, gas leak, flooding) were not tested within the last three years.

A planned mock evacuation was not conducted within the last three years. [s. 230(7)]

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 emergency plans are developed in consultation with relevant community agencies, partner facilities and resources, that they address the required components, are evaluated and updated annually, tested annually and that a mock evacuation is held every 3 years, to be implemented voluntarily.

WN #8: 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. The licensee did not ensure that they had guaranteed access to a generator that was operational within 3 hours of a power outage and that could maintain the heating system, door security system, dietary services equipment, resident-staff communication and response system and elevators.

On December 21, 2013, at approximately 11:30 p.m., a wide area of north east Toronto lost power caused by severe weather. The home was affected at approximately 3 a.m. on December 22, 2013. According to the Environmental Services Supervisor, the home was equipped with a small 10 Kw generator which was only able to sustain emergency lighting, electrical outlets and the fire panel. Registered staff who were interviewed recalled having to supervise the exit and stairwell doors and that the resident-staff communication and response system did not work. Power was not restored until December 24, 2013 at approximately 1 p.m.

According to the management of the home, the home did not have a contract with any generator companies that could deliver a larger capacity generator to the site. After unsuccessful attempts to acquire a generator through the private sector, the home was able to acquire a generator from the Province of Ontario through their emergency response program. The generator however was not delivered until December 24, 2013 at approximately 11.00 a.m. Installation was delayed due to difficulty sorting out the best method of getting the generator hooked-up. By 1:00 p.m., hydro was restored to the building and the installers abandoned the installation of the generator.

During the visit, a new large capacity generator capable of supplying power to the entire building and all essential services was being installed and was slated to be functional by December 25,2014. [s. 19. (4)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 305. Construction, renovation, etc., of homes

Specifically failed to comply with the following:

s. 305. (3) A licensee may not commence any of the following work without first receiving the approval of the Director:
1. Alterations, additions or renovations to the home. O. Reg. 79/10, s. 305 (3).
2. Other work on the home or work on its equipment, if doing the work may significantly disturb or significantly inconvenience residents. O. Reg. 79/10, s. 305 (3).

Findings/Faits saillants :

1. The licensee did not ensure that work to upgrade an elevator in the home was started without first receiving the approval of the Director (Health Capital Investment Branch). The work was identified to have significantly inconvenienced residents and as such, a work plan describing how residents would have been affected and the steps taken to address any adverse effects on the residents should have been submitted.

The home was equipped with one main passenger elevator and a much smaller service elevator. The main elevator required electrical upgrades and due to a series of set backs was out of commission 5-6 weeks longer than expected (June 30-October 4, 2014). Prior to the work, the staff of the home relied on the small service elevator for delivery of food and laundry, whereas the larger main elevator was used to transport residents from the 2nd and 3rd floors to the first floor three times a day for meals. During the disruption, the smaller elevator, which could only accommodate up to 2 residents in wheelchairs, had to be used for all of the same services with the exception of the transport of residents from the 2nd floor to the first floor dining room. Approximately 50 residents residing on the 3rd floor continued to be transported down to the 1st floor for meals. According to staff and the elevator schedule developed by the home, the process of transporting residents to the 1st floor dining room took between 1.5 to 2 hours for each meal. A large portion of the resident population was not able to use the stairs and relied on an elevator to gain access to an outdoor space and other areas of the home. According to a visitor, they reported having to wait up to 15 minutes for the smaller elevator to arrive in order to take a resident outside after 7:30 p.m. The small elevator was often being held up on another floor by staff placing it into service mode. The home's elevator schedule identified that the elevators would not be used by dietary, nursing or housekeeping staff after 6:30 p.m. [s. 305(3)]

Issued on this 27th day of October, 2014

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

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 :	2014_189120_0066
Log No. / Registre no:	T-223/460/1124-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 27, 2014
Licensee / Titulaire de permis :	DON MILLS FOUNDATION FOR SENIORS 1 Overland Drive, TORONTO, ON, M3C-2C3
LTC Home / Foyer de SLD :	THOMPSON HOUSE 1 OVERLAND DRIVE, NORTH YORK, ON, M3C-2C3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	William Krever

To DON MILLS FOUNDATION FOR SENIORS, 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)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii.equipped with a door access control system that is kept on at all times, and
   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee shall equip the basement stairwell door (zone 21) with a door access control system, and

The licensee shall equip all of the stairwell doors (excluding those located in the service corridor on the first floor) with an audible alarm that will sound at the door, and

The licensee shall connect the one stairwell door on the 1st floor and the 3 stairwell doors and the 2 entrance doors on the 2nd floor to the the audio visual enunciator panel located near the elevators on the 2nd floor. The 3rd floor stairwell doors shall be connected to the audio visual enunciator panel located near the elevators on the 3rd floor. The 4th floor stairwell doors shall be connected to the audio visual enunciator panel located near the elevators on the 4th floor.

Should an extension to comply be required, please contact the Inspector by email prior to the expiry date.

Grounds / Motifs :

1. The licensee did not ensure that all doors leading to stairways were,

ii. equipped with a door access control system, and
iii. equipped with an audible door alarm that allowed the call to be canceled only at the point of activation (at the door), and
A. that the stairwell doors were connected to the resident-staff communication and response system, or
B. was connected to an audio visual enunciator that was connected to the nurses' station nearest to the door and had a manual reset switch at each door.

Three stairwell doors were located on each of the 4 floors within the home and 2 sets of main entrance doors were available on the 2nd floor. One stairwell door (zone 21) located in the lowest level of the building was not equipped with a door access control system, allowing residents access to the stairwell from the corridor leading to the dining room and hair salon. The other 2 stairwell doors were inaccessible to the residents. The stairwell doors and the 2 main entrance doors did not alarm when tested (held open for more than 1 minute). The individual enunciator panels which were identified on floors 2-4 did not have a visual indicator installed for the various doors to alert staff as to the location of breached or disengaged door. (120)

2. The licensee did not ensure that all doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, were equipped with locks to restrict unsupervised access to those areas by residents.

One door leading to an enclosed terrace located on the 2nd floor was not locked when tested and could not be locked. The door was not a designated fire exit. Instead, the door was equipped with an alarm and key pad. The alarm was engaged at the time of the test, however the sound was wired to an enunciator panel on the 4th floor. Twenty minutes later, when visiting with staff on the 4th floor, the registered nurse had just identified that the enunciator panel was indicting both a visual and audio alert that the door to the terrace had been opened and called staff on the 2nd floor to check it. Up to that point, no staff had gone to check the door. The audio alert was not very audible unless a staff member was standing near the enunciator panel. The slow response to the alarm was of particular concern and would have been a serious risk if a confused resident exited during a cold winter day. A locking mechanism is therefore required on the terrace door which could be managed by staff for certain times of the day and year. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,

(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

(b) is on at all times;

(c) allows calls to be cancelled only at the point of activation;

(d) is available at each bed, toilet, bath and shower location used by residents;

(e) is available in every area accessible by residents;

(f) clearly indicates when activated where the signal is coming from; and

(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Order / Ordre :

The licensee shall prepare and submit a plan that identifies when and how the following activation stations will be installed in the following areas;

* 1st first floor dining room and hair salon and recreation room (if used by residents)
* 2nd floor lounges (2), family room, activity room (with sink), library, sun room, outdoor terrace
* 3rd floor lounges (2)
* 4th floor dining/activity rooms (2), lounges (2) and snoozelen room

The plan shall identify if the activation stations on the 2nd, 3rd and 4th floors will be connected to the audio visual enunciator panels that were available at the time of inspection or if other arrangements will be necessary. For the first floor, where there was no enunciator panel, the plan shall identify where the activation stations will be connected so that staff will be alerted to the sound and location of the activated station and can respond to the call.

The plan shall be submitted by email to Bernadette.susnik@ontario.ca by December 31, 2014. The plan shall be implemented by March 31, 2015. Should an extension be necessary, please contact the inspector by email prior to the expiry of the date of compliance.

Grounds / Motifs :

1. The licensee did not ensure that activation stations connected to the resident-staff communication and response system were made available in every area accessible by residents. The first floor dining room, hair salon and recreation room, 2nd floor lounges, activity room, solarium, family room, library and outdoor terrace, 3rd floor lounges, 4th floor dining/activity rooms, lounges and snoozelen room were not equipped with activation stations to trigger a visual and audio response to alert staff.
(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2015

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Order / Ordre :

The licensee shall prepare and submit a plan that identifies how and when the lighting levels in the home will be compliant with the requirements set out in the lighting table.

The plan shall be submitted by email to Bernadette.susnik@ontario.ca by December 31, 2014. The plan shall be implemented by December 31, 2015. Should an extension be necessary, please contact the inspector by email prior to the expiry of the date of compliance.

Grounds / Motifs :

1. The licensee did not ensure that the lighting requirements as set out in the lighting table were maintained.

The home was built in 1969 and therefore the section of the lighting table that applies is titled "All Other Homes". Measurements were taken of the light fixtures in specific areas throughout the home using a hand held analog illumination meter. One bedroom and one resident ensuite washroom that represented all of the resident washrooms and bedrooms were tested. Each tub/shower room, the 4th floor corridors, common washrooms, various dining rooms and all sitting areas were tested. Natural light was filtered out as much as possible (blinds/curtains pulled) to mimic night time conditions when lighting levels drop and depend on an artificial source. The meter was held level at a standard 30 inches above the floor, out away from the body and towards sources of artificial light. The outdoor condition on the day of the test was overcast. Only those areas that did not comply are listed below.

Resident Bedrooms

Second and 3rd floor bedrooms were equipped with a hanging globe-shaped light fixture with opaque glass in the centre of the room. In room #231, the lux under the light was 20. In room #229, the lux was 100. The type of bulb supplied was different in the two rooms tested. Each room was also equipped with a vanity and sink area outside of an ensuite washroom. This area was 300 lux in room #323 and 170 lux in room #231.

Resident rooms on the 4th floor were not equipped with any general room light fixtures. Room #437 was 0 lux at the foot of the bed and around the wardrobe area.

An over bed light was provided in all bedrooms, some with a wood valence and those on the fourth floor with a metal valence. In room #231, the over bed lux was adequate at 400. In room #437, the over bed light was 200 lux at the reading position over the bed and dropped to 20 lux when the meter was held near the side and foot of the bed.

The bedrooms are required to have 215.28 lux in and around the bed, wardrobes and other areas where residents would dress, sit or perform activities. The required lux for the over bed light is 376.73.

Washrooms

The resident ensuite washrooms were equipped with a large round flush mounted wall sconce which was 10 lux in #231 and 50 lux in other random washrooms. A common washroom on the 2nd floor was 200 lux at the vanity and toilet. A minimum lux of 215.28 is required in and around the vanity and toilet areas.

Tub/Shower Rooms

Shower rooms were equipped with different types of light fixtures. Those with fluorescent tube lighting were adequate, others with wall mounted fixtures and flush mounted ceiling fixtures were not adequate and did not achieve the required 215.28 lux.

2nd floor tub - 90-120 lux
3rd floor N shower - 75 lux
4th floor W tub - 10 lux (one light burnt out)

Corridors

Floors 2-4 were equipped with fluorescent tube light fixtures with a metal lens hung on the walls approximately 6 feet above the floor level. The lux levels were above 215.28 lux for the majority of the length of the corridors except for those areas where there were access points to soiled utility rooms, tub and shower rooms and storage closets.

The area in front of the large elevator on the first floor (lowest level) was equipped with 6 pot lights spaced 7 feet apart. The lux level under and between

the lights was 20-50 lux.

The corridor on the first floor that runs along side the dining room and towards and past the hair salon was equipped with pot lights and tube lights on the wall behind a valence. The lux was 50-150 lux.

All corridors are required to provide a minimum of 215.28 lux that is consistent and continuous along the length of the corridor.

Dining areas

The dining rooms on all of the floors except the first floor had sufficient lighting levels. The dining room on the first floor was equipped with chandeliers, wall sconces, fluorescent tube lights and track lights. Areas with the chandeliers were inadequate with values between 20 to 150 lux. The measurements were taken directly over the dining tables (table #3-40 lux, table #4-50 lux, table #19-20 lux, table #16-150 lux). The area with the track lighting was a walking area which was 38 feet in length. Only 7 pot lights were provided for a general lux of 100 along the length of the corridor. The minimum requirement is 215.28 lux in and around table areas and walking areas.

Activity Room

The activity space on the 2nd floor with the sink and counter had a large activity table in the centre of the room. The area around the table was 170 lux instead of the required 215.28 lux. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2015

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 27th day of October, 2014

Signature of Inspector /
Signature de l'inspecteur :

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

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