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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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
May 19, 2017	2017_539120_0029	005526-17	Critical Incident System

Licensee/Titulaire de permis

MAPLEWOOD NURSING HOME LIMITED
500 QUEENSWAY WEST SIMCOE ON N3Y 4R4

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

CEDARWOOD VILLAGE
500 QUEENSWAY WEST SIMCOE ON N3Y 4R4

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 3 & 4, 2017

Critical Incident #2768-000005-17 related to an unplanned power outage.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Associate Director of Care, Food Services Supervisor, dietary staff, personal support workers and residents.

During the course of the inspection, the inspector conducted a tour of the building and reviewed emergency plans.

The following Inspection Protocols were used during this inspection:
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. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (4) The licensee shall ensure that the emergency plans provide for the following:
1. Dealing with,
i. fires,
ii. community disasters,
iii. violent outbursts,
iv. bomb threats,
v. medical emergencies,
vi. chemical spills,
vii. situations involving a missing resident, and
viii. loss of one or more essential services. O. Reg. 79/10, s. 230 (4).

s. 230. (5) The licensee shall ensure that the emergency plans address the following components:
1. Plan activation. O. Reg. 79/10, s. 230 (5).
2. Lines of authority. O. Reg. 79/10, s. 230 (5).
3. Communications plan. O. Reg. 79/10, s. 230 (5).
4. Specific staff roles and responsibilities. O. Reg. 79/10, s. 230 (5).

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 their emergency plans provided for the loss of one or more essential services, specifically the loss of elevator and life support, emergency lighting, safety and emergency equipment, heating, dietary services equipment and the loss of the resident-staff communication and response system.

Essential services, as defined under section 19(1)(a), (b) and (c) of Ontario Regulation 79/10, includes emergency lighting, heating, dietary services equipment required to store food at safe temperatures and prepare and deliver meals and snacks, the resident-staff communication and response system, elevators and life support (i.e. PEG tube feeding systems, oxygen, dialysis), safety and emergency equipment (i.e magnetic door locking system, fire alarm system, fire panel, resident transport equipment).

During a power outage on March 8, 2017, that lasted just over 4 hours, the elevator and life support systems, emergency lighting, emergency equipment (magnetic door locking system, fire panel, fire alarm system), heating, resident-staff communication and response system, dietary refrigeration, hot holding and cooking equipment were all affected. The elevator was affected for a total of 7.5 hours as the portable generator delivered and connected at 6:05 p.m. was not able to operate the elevator.

During the inspection, the most current emergency plans were requested for review and provided by the Administrator. No written plans or procedures were developed specifically for the loss of elevator and life support, dietary services equipment, lighting, heating, safety and emergency equipment and the loss of the resident-staff communication and response system. No written information and guidance was available to staff who were present on March 8, 2017 to deal with the loss of these essential services.

The one plan that was available for review was titled "Hydro Disruption" dated May 16, 2008. The plan included information that the home or "facility was designated as a priority along with the hospitals", "if hydro electricity was disrupted, it was unlikely that it would be off form more than 2 hours", "emergency lighting would last 1 to 1.5 hours", that the "kitchen was equipped with gas cooking range to provide meals or hot fluids during electrical outages", and that the "fire alarm system had auxiliary power". Under a section titled "Emergency Generator", the plan directed department heads or charge staff to contact the electric utility for an emergency generator or their contractor. Direction was given to review the hook up instructions "inside the box". [s. 230. (4) 1.]

2. The licensee did not ensure that emergency plans addressed the following

components:

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

On March 8, 2017, no hydro was available between 1:10 p.m. and 6:05 p.m. The home did not have a generator on site that could operate all essential services during this time and it affected the following services:

*emergency lighting in hallways, corridors, stairways and exits
*heating
*emergency equipment (magnetic door locking system)
*dietary services equipment
*resident-staff communication and response system
*elevators and life support

1. On March 8, 2017, the dinner meal service was affected. The licensee`s "Food Service" plan (DSM-024) did not include any of the above noted 4 components. No written procedures were available to include under what circumstances the plan would be activated (other than in the event of a disruption), what lines of authority were in place (who reports to whom), what communications plans were in place (how staff, families, residents would be informed of plans, changes or interruptions) and specific staff roles and responsibilities. The plan included information that "steps would be taken to provide hot meals using Styrofoam insulated containers and that meals would be ordered by local caterers". The Food Services Supervisor (FSS) did not order any foods from any caterers and did not attempt to provide a hot meal. The FSS changed the menu to include only cold food items for dinner. Residents received sandwiches and a mixed green salad for dinner, cottage cheese, fruit cocktail or muffin. For those on a pureed diet, the menu options were limited to pureed bread with peanut butter and jam, strained carrots, apple sauce, pureed muffin or yogurt. Several BBQs were available outside the home, but were not used. A dietary aide identified that their portable hot holding units (cambro units) could have been used to keep foods hot once cooked, but were not used. The FSS reported that they had some portable chafing units, to keep foods hot, but they were not used. The gas stove was used to heat water for tea and coffee, but could not be overly used as no venting was available for the gas emissions and the kitchen did not have any windows for ventilation. Staff transported foods up and down the stairwells to

the six different dining areas. Hot water was not affected according to staff, however dietary staff did not use the dish washer and used paper products instead. Cold food temperatures were not affected, due to vigilance in keeping the doors to the equipment closed as much as possible.

2. The licensee`s "Hydro Disruption" plan (DSM -025) did not include any of the above noted 4 components. No written procedures were available to include under what circumstances the plan would be activated (other than when hydro is disrupted), what lines of authority were in place (who reports to whom), what communications plans were in place (how staff, families, residents would be informed of plans, changes or interruptions) and specific staff roles and responsibilities.

According to accounts from staff and residents who were present in the home on March 8, 2017, the following concerns were identified related to the lack of essential services:

a) Staff and residents reported that the corridors were dark once the emergency flood lights went out and the sun had set. Emergency lights and exit signs were illuminated only for the first 1.5 hours of the power outage. The kitchen had no windows and staff reported that it was difficult to see what they were doing and did not have sufficient portable lighting. An inadequate number of lanterns were made available to adequately keep certain areas illuminated for resident safety and to perform job duties.
b) No alternative to the resident-staff communication and response system was available with the exception of staff conducting more frequent rounds.
c) The stairwells and other doors leading to the outside or the stairwells, which were reliant on electricity to keep the magnetic locks secured, were blocked with furnishings according to the Administrator. Alternatives were not considered. Concerns were raised with respect to safe egress during an emergency.
d) Residents had to remain on their respective floors for the duration of the outage (1:10 to 7:30 p.m.). No emergency transfer equipment was available for residents should transport up and down stairs be required for residents who could not walk.
e) Resident's therapeutic mattresses deflated and alternative mattresses were not provided. According to one personal support worker, some residents could not have an afternoon nap. According to the maintenance person, some regular mattresses were available in the basement, but the staff did not request them. A staff member stated that they did not know that extra mattresses were available. [s. 230. (5)]

3. The licensee did not test the emergency plans related to the loss of essential services on an annual basis, including the arrangement with the community agencies, partner

facilities and resources that will be involved in responding to an emergency.

The Administrator, who was newly employed at the home, was not aware of when the emergency plans were last tested related to the the loss of essential services. The local municipality (Town of Simcoe) had not been contacted to determine if they were able to respond to an emergency and what, if any resources they could provide.

The licensee's "Hydro Disruption" plan dated May 16, 2008, identified that an emergency generator could be acquired by contacting Tillsonburg Hydro. The number that was included in the plan belonged to the Town of Tillsonburg, which did not service the citizens of the Town of Simcoe. The plan further directed the reader that if the generator could not be acquired by the Town of Tillsonburg, then the alternative was to use their contracted supplier in Tillsonburg, Ontario. [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 provide for the loss of one or more essential services, specifically the loss of elevator and life support, emergency lighting, safety and emergency equipment, heating, dietary services equipment and the loss of the resident-staff communication and response system, that the plans address the required 4 components, and that the plans are tested on an annual basis related to the loss of essential services, including the arrangement with the community agencies, partner facilities and resources that will be involved in responding to an emergency, to be implemented voluntarily.

WN #2: 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 a generator was operational within 3 hours of a power outage and that could maintain the heating system, emergency lighting in hallways, corridors, stairways and exits and essential services including;

* dietary services equipment required to store food at safe temperatures and prepare and deliver meals and snacks,
* the resident-staff communication and response system,
* elevators and life support, and
* safety and emergency equipment.

On March 8, 2017, a major wind storm affecting the greater Norfolk Region caused power outages within the Town of Simcoe and other surrounding towns. The long term care home lost power at approximately 1:10 p.m. The expected duration of the outage was not known at the time, but the utility provider for the municipality anticipated that the outage was going to last approximately 4 hours. The administrator waited for one hour and called a generator supplier located 40 kilometers away. The supplier did not have any generators available and had to acquire one from another town located 84 kilometers away. The generator was delivered and connected by 6:05 p.m. The above noted essential services were operational with the exception of the elevator. The power was fully restored to the Town of Simcoe by 7:30 p.m.

The licensee was required to have guaranteed access to a generator, whether through a supplier or other means, within 3 hours of a power outage. As the licensee did not have their own generator on site, a letter of agreement dated February 7, 2007, was established with a contractor located in Tillsonburg, Ontario to provide a generator when requested. The agreement included a statement that "in the event of a power failure and providing there is a generator available from either the Town of Tillsonburg or a specified company, the contractor agrees to be willing and able to deliver and hook up a generator to supply temporary power to the home" and that they "would not be responsible if a catastrophic event occurred resulting in limited or unavailable generators". The letter of agreement did not provide for any guarantees that the licensee would receive a generator, indicating only that if one was available from one of two locations, that one would be delivered. The letter of agreement did not include any reference to time frames for delivery and hook-up or what size or capacity the generator would be delivered to ensure that all essential services in the long term care home would be operational. [s. 19. (4)]

Issued on this 19th day of May, 2017

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

Original report signed by the inspector.