Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 6, 2019	2019_539120_0031	020165-19, 020541-19	Critical Incident System

Licensee/Titulaire de permis

Park Lane Terrace Limited
284 Central Avenue LONDON ON N6B 2C8

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

Park Lane Terrace
295 Grand River Street North PARIS ON N3L 2N9

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): October 25 & 30, 2019

This Critical Incident Inspection was conducted concurrently with Critical Incident Inspection #2019-549107-0013.

The following critical incidents were reviewed;

Log #020165-19 related to an internal flood.
Log #020541-19 related to the licensee's sewage disposal system.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Environmental Services, housekeeping staff, personal support workers, residents and a contractor.

During the course of the inspection, the inspector toured all home areas, including random resident rooms and common areas and reviewed emergency plans, maintenance policies and procedures, maintenance audits and external contractor service reports.

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)
- 2 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	Légende 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. 90. Maintenance services

Specifically failed to comply with the following:

**s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and O. Reg. 79/10, s. 90 (1).
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).**

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, that there were procedures and schedules in place for routine, preventive and remedial maintenance.

On an identified date in August 2019, a wind and rain storm in the Paris area caused rain to leak underneath the roofing shingles causing water leaks into several resident rooms on an identified home area. A roofing company attended the home 13 days later and provided a quote for the repair, followed by the installation of a tarp on the roof. According to the roofer, who was interviewed four days post inspection, no repairs were completed at the time as the roofer stated that the licensee wanted to wait until spring to complete the repairs. On a specified date in October 2019, Ministry of Long Term Care Inspectors were conducting an inspection in the same identified home area when they witnessed rain water leaking into several resident rooms and a common area via the top of the window frames.

According to the Director of Environmental Services (DES), a call was placed to the roofing company on a specified date in October 2019, to install an additional tarp and to obtain a date for the replacement of the shingles. According to the roofer, a tarp was placed over a different section of the same home area in October 2019. The roofer confirmed that they did not receive a commitment to replace the shingles until October 2019. Once the final approval was received, shingles were delivered to the home within a week, however work on the roof was delayed due to wet weather. As of four days post inspection, the repairs have not been completed.

The licensee's maintenance related procedures and schedules were reviewed. However, no written procedures were in place to address the expected remedial and preventative

steps to be taken for the condition of the building exterior, including the roof. Steps would include but not be limited to who would conduct the preventative inspections and at what frequency, what an unacceptable condition would entail, who would conduct the repairs and a reasonable response time for repairs. The DES stated that they and a corporate representative toured the exterior of the building in the late spring and conducted an inspection of the roof, down spouts and eaves. However, no documentation was available for review as to the date of the inspection and what was inspected and identified.

A reference to a "Preventative Maintenance Checklist" was noted in a policy entitled "Maintenance - Preventative Maintenance", Section 3.3 (undated) . It included a list of building surfaces, equipment and systems to inspect, including the roof. However, the frequency was not listed. The DES reported that they did not use the checklist. According to the Executive Director, the maintenance policies were being redeveloped corporately and would be distributed in 2020.

The licensee did not ensure that as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, that there were procedures and schedules in place for routine, preventive and remedial maintenance. [s. 90. (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 as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, that procedures and schedules are in place for routine, preventive and remedial maintenance, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (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).

Findings/Faits saillants :

1. The licensee failed to ensure that in developing the plans, that hazards and risks that may have given rise to an emergency impacting the home were identified and assessed.

The licensee's emergency plans did not include any plans related to sewage disposal limitations or flooding. The Executive Director reported that they were not aware of any recent assessments with respect to risks or hazards that may impact residents and the home. Both flooding and sewage disposal limitations can give rise to an emergency, causing damage, increasing safety risks and reducing the capacity for staff to provide adequate care and services to residents. Failure to identify and assess potential emergencies and to subsequently develop and implement a written plan may lead to ineffective or delayed responses.

A. Two critical incident reports were submitted by the licensee in relation to a major system supporting the home. The first incident occurred on a specified date in September 2019 and the second on a specified date in October 2019, where the home's sewage disposal system failed to pump accumulated sewage from a holding tank located on the licensee's property to the municipal trunk line located under the main road in front of the property. On both occasions, the pumps located in the holding tank became clogged with linens/hygienic products. The licensee was alerted of the failure via alarms and immediately contacted a contractor to evaluate the situation on both occasions. While waiting for a contractor to arrive, examine the system and to pump out the tank, water usage within the home had to be limited. Linen and personal clothing laundering were affected as well as mechanical dish washing and resident bathing.

According to the Director of Environmental Services, similar incidents had occurred in the past and staff therefore were able to manage the situation so that negative outcomes

were minimized, however, the potential for a full evacuation was possible. Any circumstances impacting the ability to remove the sewage would require an evacuation. During the second sewage system failure, which lasted for eight days, the frequency of sewage removal by the contractor was increased to every eight hours in order for staff to continue bathing residents and to be able to flush toilets and use the hand sinks. However laundry and mechanical dish washing were still affected.

B. A critical incident report submitted by the licensee on a specified date in October 2019, identified that on the same date, a hot water re-circulation line located in the ceiling above the corridor of an identified home area burst open. Staff who were working during this time had to contact the Director of Environmental Services (DES) via telephone as to the location of the shut off valves. One shut-off valve was found but did not shut the water off completely and the water poured from the line onto the carpeted corridor for a total of 20 minutes. Once the plumbing contractor arrived on site, the second shut off valve was found. According to Ministry of Long Term Care Inspectors who were on site during the incident, approximately two to three inches of water had accumulated on the carpet and had spread down the length of the corridor. The water spread into two resident rooms and washrooms. Thirty-one residents were evacuated to the dining room for several hours until the water was removed.

According to the DES, clean up was completed by housekeeping staff, using a floor machine which was able to extract the water. A restoration company was contacted on the same date as the incident and arrived on the same date to assess the extent of moisture intrusion into walls and under flooring. Results indicated that several areas were determined to be unacceptable and baseboards were removed from one resident washroom and two bedrooms. During the first date of the inspection, mould was observed on the dry wall along the bottom six inches of the walls in and identified resident washroom. However, it was suspected that the mould had already been present from other types of past minor floods (toilet overflow). At the time, no firm plans were in place as to who and when the affected drywall would be replaced.

The licensee, in developing their written emergency plans, did not identify flooding or sewage disposal limitations as a hazard or risk giving rise to a potential emergency impacting the home. [s. 230. (3)]

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 in developing the plans, 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 surrounding vicinity or community, to be implemented voluntarily.

Issued on this 15th day of November, 2019

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

Original report signed by the inspector.