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
Dec 21, 2016	2016_539120_0075	030798-16	Complaint

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

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

ORCHARD TERRACE CARE CENTRE
199 GLOVER ROAD STONEY CREEK ON L8E 5J2

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): November 30, 2016

Complaint #030798-16 related to a power outage on October 20, 2016 and concerns that a generator was not available.

During the course of the inspection, the inspector(s) spoke with the Environmental Services Supervisor (ESS).

During the course of the inspection, the inspector reviewed the licensee's emergency plans related to a loss of essential services.

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)**
- **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 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 three hours of a power outage and that was able to maintain the required services identified below:

*emergency lighting in hallways, corridors, stairways and exits
*dietary services equipment
*heating
*resident-staff communication and response system
*safety and emergency equipment (fire panel, magnetic door locking systems)

The home is a structural class C home that was not equipped with a generator when initially built that could support all of the essential services listed above and did not install or purchase any portable generators in the following years. On October 20, 2016, at approximately 5:30 p.m., an accident occurred involving a vehicle and a hydro transfer pole which subsequently cut the power to the home until approximately 11:20 p.m. The management staff did not contact a service provider to deliver a generator to the home within three hours of the power outage as required. The administrator who was present during the incident was no longer employed at the home and was not available for interview, however the Environmental Services Supervisor (ESS) who was present was interviewed. A critical incident report was also submitted by the home summarizing how the situation was managed. The ESS reported that she and other management staff were not provided with any firm time frames for the restoration of the power and decided that at the six-hour mark, either evacuation plans would be initiated or a generator supplier would be contacted to deliver a generator. The decision to wait six hours was not identified in any of the licensee's emergency plans. The only reference made to time was identified in their "Loss of Hydro" plan dated December 9, 2013 which stated that if the "power supply will not be restored for an extended period of time (more than three hours), initiate evacuation".

A contract with a generator supplier or company identifying that guaranteed access to a generator could not be provided at the time of the inspection. The ESS stated that they would contact their corporate office for a copy of the contract, however as of the date of this report, no contract was provided for review.

Essential services that were affected during the power outage included emergency lighting in corridors (after the first 30 minutes), dietary services equipment (cooking, hot holding, cold holding), the staff communication and response system, safety and emergency equipment (fire systems, door access control systems) and heating. The lack of services however did not significantly impact residents as they had just finished their

dinner meal service. Additional staff were allocated, refrigeration and door security was monitored, a fire watch was established, outdoor air temperatures were mild and did not affect indoor air temperatures, resident baths and showers were re-scheduled for the following day, mechanical floor lifts were available with back up batteries and emergency portable lights were used. The staff at the home successfully managed residents throughout the duration of the power outage, however the licensee did not comply with provisions of section 19(4) of Ontario Regulation 79/10 to ensure that a generator was on site and operational within three hours of the power outage. [s. 19. (4)]

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. 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).

Findings/Faits saillants :

1. The home's emergency plans did not include information for staff regarding the loss of the resident-staff communication and response system, emergency lighting, safety and emergency equipment (i.e magnetic door locking system, fire alarm, fire panel) and life support equipment (i.e PEG tube feeding systems, oxygen, dialysis, therapeutic surfaces). The home's "Loss of Hydro" plan identified some information regarding a loss of heat but was is not in keeping with s. 230(5) of Ontario Regulation 79/10.

Essential services, as defined by section 19 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 and life support, safety and emergency equipment.

No written plans for the above identified essential services were available for review. As per the "Loss of Hydro" plan (EPM I-05-10, dated December, 9, 2013), the reader was referred to "additional emergency procedures". However, the list of additional emergency procedures did not include any reference to safety and emergency equipment or the resident-staff communication and response system. [s. 230. (4) 1.]

2. The licensee did not ensure that emergency plans addressed components related to lines of authority, a communications plan and specific staff roles and responsibilities.

The licensee's "Loss of Hydro" and "Loss of Communication - Telephone system" plans dated December 9/13 were reviewed.

On October 20, 2016, hydro (electrical power) was not available between 5:30 p.m. and 11:20 p.m., disrupting all essential services within the home as well as electronic record retrieval. The home did not have a generator on site that could operate all essential services within three hours of the power loss and for the duration of the power loss. Staff were able to use cell phones, however computer systems were not operational.

The "Loss of Hydro" plan did not include a communications plan which would include but not be limited to communication strategies between all levels of staff, between staff and residents, between staff and families and between families and residents in the event of a power outage. The plan included staff roles and responsibilities for administration, director of nursing, nursing staff, dietary, laundry, housekeeping, activation and maintenance staff but they were limited. The tasks, with the exception of nursing and

dietary staff were limited to shutting off equipment and reporting to managers for direction. No direction was available for the managers of the various departments other than to report to their Administrator for further direction.

The "loss of communication - telephone system" plan did not identify a line of authority, a communications plan or staff roles and responsibilities. A clear line of authority was not included or referenced. A sole reference to staff roles and responsibilities included a statement that "staff will be requested to run messages to all floors/departments". No further details were provided. The plan included a reference to using a "home cell phone" to contact service providers. The plan did not include the loss of other communication systems such as internet and use of computer soft ware programs to maintain electronic records. The registered staff in the home conducted many processes electronically, on computers to manage daily tasks such as medication administration and recording of resident signs and symptoms, complaints and daily activities. No information was available to guide staff in acquiring the information if such information was mostly kept in electronic format. [s. 230. (5)]

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 home's emergency plans include information for staff regarding the loss of the resident-staff communication and response system, emergency lighting, safety and emergency equipment and life support equipment and to ensure that emergency plans address all components as outlined in s. 230(5), to be implemented voluntarily.

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

Issued on this 22nd day of December, 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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2016_539120_0075
Log No. / Registre no:	030798-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 21, 2016
Licensee / Titulaire de permis :	RYKKA CARE CENTRES LP 3200 Dufferin Street, Suite 407, TORONTO, ON, M6A-3B2
LTC Home / Foyer de SLD :	ORCHARD TERRACE CARE CENTRE 199 GLOVER ROAD, STONEY CREEK, ON, L8E-5J2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Agnes Jankowski

To RYKKA CARE CENTRES LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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. 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).

Order / Ordre :

1. The licensee shall provide the inspector with a copy of their most current contract identifying who the generator supplier is and their contact information, what services they will provide and that they can guarantee access to a generator that will be operational within three hours of a power outage and that can maintain the following essential services;

*emergency lighting in hallways, corridors, stairways and exits
*dietary services equipment
*heating
*resident-staff communication and response system
*safety and emergency equipment (fire panel, magnetic door locking systems)

2. The licensee shall revise their emergency plan titled "Loss of Hydro" dated December 9, 2013 so that it clearly identifies the time frame the licensee has to contact their corporate support services in the event of a power outage, who would be responsible for ordering the generator and the time frames for the installation of an operational generator in keeping with s. 19(4) of Ontario Regulation 79/10.

A copy of the contract shall be emailed to Bernadette.susnik@ontario.ca by December 30, 2016 and a revised emergency plan shall be emailed to Bernadette.susnik@ontario.ca by January 13, 2017.

Grounds / Motifs :

1. The licensee did not ensure that they had guaranteed access to a generator

that was operational within three hours of a power outage and that was able to maintain the required services identified below:

*emergency lighting in hallways, corridors, stairways and exits
*dietary services equipment
*heating
*resident-staff communication and response system
*safety and emergency equipment (fire panel, magnetic door locking systems)

The home is a structural class C home that was not equipped with a generator when initially built that could support all of the essential services listed above and did not install or purchase any portable generators in the following years. On October 20, 2016, at approximately 5:30 p.m., an accident occurred involving a vehicle and a hydro transfer pole which subsequently cut the power to the home until approximately 11:20 p.m. The management staff did not contact a service provider to deliver a generator to the home within three hours of the power outage as required. The administrator who was present during the incident was no longer employed at the home and was not available for interview, however the Environmental Services Supervisor (ESS) who was present was interviewed. A critical incident report was also submitted by the home summarizing how the situation was managed. The ESS reported that she and other management staff were not provided with any firm time frames for the restoration of the power and decided that at the six-hour mark, either evacuation plans would be initiated or a generator supplier would be contacted to deliver a generator. The decision to wait six hours was not identified in any of the licensee's emergency plans. The only reference made to time was identified in their "Loss of Hydro" plan dated December 9, 2013 which stated that if the "power supply will not be restored for an extended period of time (more than three hours), initiate evacuation". Further, the plan identified that "if power outage is anticipated to be of long duration, contact Vice President of Operations during regular business hours or the RMI support line after hours". No definitions were given for "long duration" and no guidance was provided regarding when the the licensee would contact their corporate office regarding the need to order a generator or who would be responsible for ordering it and when.

A contract with a generator supplier or company identifying that guaranteed access to a generator could not be provided at the time of inspection. The ESS stated that they would contact their corporate office for a copy of the contract, however as of the date of this report, no contract was provided for review.

Essential services that were affected during the power outage included emergency lighting in corridors (after the first 30 minutes), dietary services equipment (cooking, hot holding, cold holding), the staff communication and response system, safety and emergency equipment (fire systems, door access control systems) and heating. The lack of services however did not significantly impact residents as they had just finished their dinner meal service. Additional staff were allocated, refrigeration and door security was monitored, a fire watch was established, outdoor air temperatures were mild and did not affect indoor air temperatures, resident baths and showers were re-scheduled for the following day, mechanical floor lifts were available with back up batteries and emergency portable lights were used. The staff at the home successfully managed residents throughout the duration of the power outage, however the licensee did not comply with provisions of section 19(4) of Ontario Regulation 79/10 to ensure that a generator was on site and operational within three hours of the power outage.

This Order is being made based on the findings of non-compliance with Ontario Regulation 79/10, s.19(4) as outlined in the above grounds and based on three factors, severity, scope and compliance history in keeping with s.299(1) of the Regulation. In respect of severity (potential of harm or risk of harm to residents), there was minimal harm to residents, in respect of scope, the incident affected all residents within the home and there has not been any non-compliance issued under s. 19 in the past 3 years.

(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 13, 2017

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 21st day of December, 2016

Signature of Inspector /
Signature de l'inspecteur :

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

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