Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
May 6, 2014	2014_178102_0022	000257-14	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

THORNTONVIEW
186 THORNTON ROAD SOUTH, OSHAWA, ON, L1J-5Y2

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

WENDY BERRY (102)

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): April 25, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Environmental Services Manager.

During the course of the inspection, the inspector(s) reviewed a critical incident related to a power outage and loss of essential services which occurred on December 22 and 23, 2013.

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 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. (1) Subject to subsections (2) to (4), every licensee of a long-term care home shall ensure that the home is served by a generator that is available at all times and that has the capacity to maintain, in the event of a power outage,
(a) the heating system; O. Reg. 79/10, s. 19 (1).
(b) emergency lighting in hallways, corridors, stairways and exits; and O. Reg. 79/10, s. 19 (1).
(c) 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, safety and emergency equipment. O. Reg. 79/10, s. 19 (1).

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. CI # 2534 000005-14 identifies that a power outage occurred on December 22, 2013 which lasted approximately 22 hours.

The generator provided on site connected to the "A" side of the home is not set up to maintain all required essential services, which includes safety and emergency equipment:
-magnetic door locking system
-fire detection system. [s. 19. (1) (c)]

2. The "C" side of the home, which is occupied by 104 residents, is not connected to the on site generator. The heating system, emergency lighting and essential services in the "C" side of the home were not functional during the 22 hour power outage.

The home did not have guaranteed access to a generator for the "C" side of the home, that would be operational within 3 hours of a power outage that would maintain everything required under clauses (1) (a)(b) and (c).

Noted that a generator was delivered to the site on December 23, 2014. It was not hooked up as the power was restored. Also noted that an agreement is now in place for delivery of a generator to the site within 3 hours. The connection requires the services of an electrician to connect it and an electrical safety inspection prior to use. [s. 19. (4)]

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 on site generator that serves the "A" side of the home is set up to power all required essential services; and that measures are in place to ensure that the "C"side of the home has guaranteed access to a generator that will be operational within 3 hours of a power failure, to be implemented voluntarily.

WN #2: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. A power outage and subsequent loss of essential services affecting the home on December 22 and 23, 2014 was verbally reported to the after hours call center within the required time frame for reporting a critical incident.

CIR # 2534 000005-14 relating to the loss of essential services on December 22, 2013 was submitted on April 01, 2014.

The licensee did not make a critical incident report in writing within 10 days of the incident. [s. 107. (4)]

Issued on this 6th day of May, 2014

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

Wendy BERRY