



**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 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**

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de
Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 29, 2017; Jan 2, 2018	2017_626501_0025	025839-17, 025841-17, 026066-17	Complaint

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale
Development LP
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Bloomington Cove Care Community
13621 Ninth Line Stouffville ON L4A 7X3

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

SUSAN SEMEREDY (501)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 29, 2017 and January 2, 2018.

**The following intakes related to the temperature in the home were inspected:
Intake #026066-17 and complaint intakes #025839-17 and 025841-17.**

During the course of the inspection, the inspector(s) spoke with the Director of Care, maintenance workers, Environmental Services Manager, corporate Senior Building Services Projects Manager, registered nursing staff, Personal Support Workers, residents, and Substitute Decision Makers (SDMs).

The inspector reviewed maintenance logs, temperature monitoring logs and relevant policies and procedures and observed residents and staff.

**The following Inspection Protocols were used during this inspection:
Safe and Secure Home**

During the course of this inspection, Non-Compliances were issued.

1 WN(s)

0 VPC(s)

1 CO(s)

0 DR(s)

0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:

Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:



REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / DE L'INSPECTION	NO	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 8. (1)	CO #901	2017_626501_0025		501

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
<p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records



Specifically failed to comply with the following:

- s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
- (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
 - (b) is complied with. O. Reg. 79/10, s. 8 (1).**

Findings/Faits saillants :

1. The licensee failed to ensure that the where the act of the regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedures strategy or system is complied with.

Ontario Regulation 79/10 s. 230 requires the licensee to have an emergency plan that provides for the loss of one or more essential services.

Review of intake #026066-17 revealed the home submitted a Critical Incident Report on November 13, 2017, related to a failure/breakdown of the home's heating system due to a failure of a boiler. The issue was noted as resolved in an amendment dated November 16, 2017. An inquiry took place on December 27, 2017, where the Director of Care stated the temperature in the home was fine and the issue was resolved. The DOC faxed temperature logs to the Toronto Service Area Office which indicated that most temperatures were above 72 degrees Fahrenheit (equivalent to 22.2 degrees Celsius) except for the week of November 13, 2017.

Review of intakes #025841-17 and #025839-17 revealed the MOHLTC received complaints on identified dates, related to intake #026066-17. The inspector spoke with a complainant on an identified date who stated that when the boiler was down the home was very cold. The complainant stated that the home is currently being renovated and there are some areas that remain uncomfortably cold. He/she also stated that since the boiler was repaired the home has put in heaters in the hallways but the rooms remain chilly. According to the complainant residents are mostly kept in the dining rooms where it is warm.

The inspector entered the home at approximately 1340 hours on December 29, 2017. Interview with maintenance person #100 revealed that the temperatures taken and logged on a daily basis are those taken in the hallways by maintenance and that he/she does not take temperatures in resident rooms. The maintenance person #100 took temperatures of the bed areas in the following rooms and the inspector recorded the temperatures in Celsius:

Rooms on an identified floor:

Identified Room #1: 18.3 to 18.9
Identified Room #2: 17.2 to 18.9
Identified Room #3: 17.7 to 20
Identified Room #4: 16.7
Identified Room #5: 17.2
Identified Room #6: 18.3 to 22
Identified Room #7: 18.3 to 20.6

Rooms on another identified floor:

Identified Room #8: 16.7
Identified Room #9: 19.4
Identified Room #10: 20.6
Identified Room #11: 19.4
Identified Room #12: 20.0

Interview with the DOC revealed that he/she was not aware the resident rooms were as cold as the above temperatures. The DOC and inspector took temperatures in some of the same rooms and the readings were similar. The DOC indicated that since the home was under renovation the temperature of the home has been difficult to maintain and confirmed that today's temperatures in the resident rooms were not maintained at a minimum of 22 degrees Celsius.

Review of the home's policy #XV-A-20.10 titled "Management of Risks Associated with Extreme Cold", revised January 2015, revealed that in the event of a failure of the home's heating system the home shall direct maintenance to monitor and document building temperatures every 30 minutes to ensure the temperature does not drop below 20 degrees Celsius in any occupied areas and implement an evacuation plan if building temperatures fall below 15 degrees Celsius.

In a further interview with the DOC, he/she acknowledged that the home was not



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monitoring the building temperatures every 30 minutes.

Due to the severity of harm being minimal or potential for actual harm and the scope being widespread an immediate order is being served.

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 11th day of January, 2018

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

Original report signed by the inspector.



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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

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) : SUSAN SEMEREDY (501)

Inspection No. /

No de l'inspection : 2017_626501_0025

Log No. /

No de registre : 025839-17, 025841-17, 026066-17

Type of Inspection /

Genre d'inspection: Complaint

Report Date(s) /

Date(s) du Rapport : Dec 29, 2017; Jan 2, 2018

Licensee /

Titulaire de permis : The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd, Suite 300, MARKHAM, ON,
L3R-0E8

LTC Home /

Foyer de SLD : Bloomington Cove Care Community
13621 Ninth Line, Stouffville, ON, L4A-7X3

Name of Administrator /

**Nom de l'administratrice
ou de l'administrateur :** JANET IWASZCZENKO

To The Royale Development GP Corporation as general partner of The Royale Development LP, you are hereby required to comply with the following order(s) by the date(s) set out below:



**Ministry of Health and
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Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term Care
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Order # /**Ordre no :** 901**Order Type /****Genre d'ordre :** Compliance Orders, s. 153. (1) (a)**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall comply with #6 and #9 of the home's policy titled, Management of Risks Associated with Extreme Cold.

The licensee shall immediately:

1. Monitor the temperature of identified rooms every 30 minutes and submit these temperature logs to the MOHLTC on December 30, 31, 2017, and January 1, 2018, before 1600 hours.
2. Monitor the residents in the above rooms every shift and document the status of each of these residents and whether extra blankets were offered and accepted.
3. Monitor all residents who reside on the second and first floor home areas for signs or symptoms related to the cold, including hypothermia. Document any change in status of affected residents and what interventions were offered and accepted.

Grounds / Motifs :

1. The licensee failed to ensure that the where the act of the regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedures strategy or system is complied with.

Ontario Regulation 79/10 s. 230 requires the licensee to have an emergency

plan that provides for the loss of one or more essential services.

Review of intake #026066-17 revealed the home submitted a Critical Incident Report on November 13, 2017, related to a failure/breakdown of the home's heating system due to a failure of a boiler. The issue was noted as resolved in an amendment dated November 16, 2017. An inquiry took place on December 27, 2017, where the Director of Care stated the temperature in the home was fine and the issue was resolved. The DOC faxed temperature logs to the Toronto Service Area Office which indicated that most temperatures were above 72 degrees Fahrenheit (equivalent to 22.2 degrees Celsius) except for the week of November 13, 2017.

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The inspector entered the home at approximately 1340 hours on December 29, 2017. Interview with maintenance person #100 revealed that the temperatures taken and logged on a daily basis are those taken in the hallways by maintenance and that he/she does not take temperatures in resident rooms. The maintenance person #100 took temperatures of the bed areas in the following rooms and the inspector recorded the temperatures in Celsius:

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Identified Room #4: 16.7

Identified Room #5: 17.2

Identified Room #6: 18.3 to 22

Identified Room #7: 18.3 to 20.6

Rooms on another identified floor:

Identified Room #8: 16.7



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Identified Room #9: 19.4
Identified Room #10: 20.6
Identified Room #11: 19.4
Identified Room #12: 20.0

Interview with the DOC revealed that he/she was not aware the resident rooms were as cold as the above temperatures. The DOC and inspector took temperatures in some of the same rooms and the readings were similar. The DOC indicated that since the home was under renovation the temperature of the home has been difficult to maintain and confirmed that today's temperatures in the resident rooms were not maintained at a minimum of 22 degrees Celsius.

Review of the home's policy #XV-A-20.10 titled "Management of Risks Associated with Extreme Cold", revised January 2015, revealed that in the event of a failure of the home's heating system the home shall direct maintenance to monitor and document building temperatures every 30 minutes to ensure the temperature does not drop below 20 degrees Celsius in any occupied areas and implement an evacuation plan if building temperatures fall below 15 degrees Celsius.

In a further interview with the DOC, he/she acknowledged that the home was not monitoring the building temperatures every 30 minutes.

Due to the severity of harm being minimal or potential for actual harm and the scope being widespread an immediate order is being served. (501)

**This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Immediate**



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de soins de longue durée*, L.O. 2007, chap. 8

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, commercial courier 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



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When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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.



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RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le/la titulaire de permis souhaite que le directeur examine;
- c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603



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Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière
d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 29th day of December, 2017

**Signature of Inspector /
Signature de l'inspecteur :**



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Name of Inspector /

Susan Semeredy

Nom de l'inspecteur :

Service Area Office /

Bureau régional de services : Toronto Service Area Office