



**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**

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de
London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
Jun 11, 2019	2019_614145_0006	002938-19	Critical Incident System

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

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

Caressant Care on Bonnie Place
15 Bonnie Place St Thomas ON N5R 5T8

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

KARIN MUSSART (145)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): May 15, 2019

During the course of the inspection, the inspector(s) spoke with Administrator, Environmental Services Supervisor and maintenance person.

During the course of the inspection, the inspector toured the home, reviewed policies and procedures relating to preventive maintenance.

**The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance**

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

1 WN(s)

0 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services



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Specifically failed to comply with the following:

- s. 15. (2) Every licensee of a long-term care home shall ensure that,**
- (a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
 - (b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
 - (c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

Findings/Faits saillants :



1. The licensee has failed to ensure that furnishings and the home were maintained in a good state of repair.

i) On May 15, 2019, a tour of the home was conducted, focusing on the Greenhouse activity room, which according to the submitted Critical Incident System (CIS) report 2730-000004-19, was the source of the water intrusion.

ii) Incident occurred on February 2, 2019 at 18:15. Was reported to MOHLTC on February 3, 2019 at 18:38. The CIS report was amended on February 12, 2019 at 13:47 to provide more detail after the contractor had viewed the damaged area. As reported in the CIS report, a cap on a pipe "blew off" according to the plumber who was called in to assess the damage, likely due to pipes thawing. The pipe was located in the "Greenhouse" meeting room. Water ran out of the room into electrical room, office, nursing station, med room, small dining room and a part of the large dining room as well as hallway in this area. Also, water seeped into a nearby resident room beside the "Greenhouse", but water in this room was minimal. In meeting with the contractor Feb. 12, 2019, it was determined that the only room that will require repairs will be the "Greenhouse" meeting room. No resident areas will require repairs by the contractor.

iii) Viewed the "Greenhouse" room on May 15, 2019. Inspector #145 took several photographs of the damaged room. Spoke with one of the Maintenance staff and the Environmental Services Manager (ESM) at 14:35. The ESM confirmed that the damage was due to two issues. Issue # 1: water leaking behind the far outside wall on the left side corner. A sink that was there previously had been removed and the line capped. Capped section was leaking due to cap failure inside the wall likely due to freeze and thaw conditions. Issue # 2: Skylight leaking. Upon inspection, drain holes that allow water to drain were clogged with debris. This resulted in the water unable to drain away and enter the building. Drains were subsequently cleaned and re-caulked, preventing further water intrusion.

iv) While steps were taken to prevent recurrence of water infiltration into the home, the damage caused by the burst pipe and the leaking skylight has not been repaired. The ESM advised that there was not a time frame for repairs to be completed and the room to be available for resident use. Spoke with the home Administrator, at approximately 15:00 on May 15, 2019, regarding the time frame for repairs. The Administrator advised that no scheduled repair plan was in place for the "Greenhouse" activity room, to make it usable for residents, which is part of the resident activity space. [s. 15. (2) (c)]



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Issued on this 11th day of June, 2019

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

Original report signed by the inspector.