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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 26, 2018	2018_539120_0001	028458-16, 026436-17, 027572-17	Complaint

Licensee/Titulaire de permis

955464 Ontario Limited
3700 Billings Court BURLINGTON ON L7N 3N6

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

Crescent Park Lodge
4 Hagey Avenue Fort Erie ON L2A 5M5

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): January 2, 3, 2018

This complaint inspection was conducted concurrently with an inspection related to a critical incident (002377-17) that was submitted by the licensee regarding a gas leak in the home in 2017. Several complaints were received regarding the incident. A separate complaint (028458-16) was also reviewed regarding cooling requirements during summer months, dietary services and indoor air quality.

During the course of the inspection, the inspector(s) spoke with the Administrator, corporate Environmental Services Manager, maintenance person, personal support workers, residents, a family member, housekeepers, registered staff, fire inspectors, maintenance contractor and a gas company representative.

During the course of the inspection, the inspector toured the home, checked the operation of exhaust and air supply systems in resident occupied areas, took air temperatures, reviewed air temperature logs, reviewed resident clinical records including heat stress assessments, emergency plans, maintenance policies and procedures, maintenance service reports, hot weather related policies and procedures and observed a noon time meal service.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Personal Support Services
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **4 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee did not ensure that the home was a safe environment for its residents.

A complaint was received that gas-like odours were detected in the home in 2017. According to the complainant, who was visiting a resident in the evening, the odour was very strong and produced a negative health response. The complainant was concerned

and informed several personal support workers (PSW), who did not follow an established response protocol, which included contacting the fire department. The response the complainant received from two separate PSWs was that they were aware of the odours, that there was nothing wrong, that the maintenance person had been working on the gas fire places earlier in the day and that there was nothing else that could be done. One PSW stated that they would inform the Administrator, who was not on site at the time. The complainant subsequently left the home and contacted the fire department before returning. Thirty minutes later, Emergency Medical Services employees who were in the home for an unrelated matter, noticed a gas-like odour, and called 9-1-1. A registered nurse (RN) subsequently contacted their maintenance person, who was off site, and was instructed to shut down the roof top air make up units (RTAMU), which provided heated fresh air to the building. The fire department arrived 15 minutes later, followed by the gas company. According to the fire inspector, the RTAMUs were turned back on and windows that were found open were closed and meters were used by both the gas company and the fire department to measure carbon monoxide (an odourless, tasteless gas) and other compounds associated with a gas leak. All gas fired appliances in the home were checked to determine the source of the leak. These included the RTAMUs, fire places, gas stoves and other combustion appliances. The leak was linked to one RTAMU which served two resident occupied corridors in the home. A gas company representative reported that their technician measured one RTAMU for carbon monoxide outside, which was reported to be approximately 800 parts per million (ppm) and the ambient levels in the home were measured to be 4 ppm. A level of 25 ppm or above over an eight hour period can cause headaches, dizziness or nausea and a level above 100 ppm can cause death (Occupational Health and Safety Act, 1990). The RTAMU with the leak was locked out, inspected, parts ordered and made fully functional within 10 days of the gas leak, by a licensed and qualified heating/ventilation and air conditioning (HVAC) contractor. The component responsible for the leak had been newly installed nine days prior to the gas leak and was identified to have been faulty.

Earlier in the day, according to the administrator, a staff member reported a gas smell in the main lounge to the RN on duty. The RN contacted the maintenance person via telephone and was instructed to shut off the gas fire place in the main lounge. Three hours later, the RN was informed by the same staff member that the smell of gas was still evident. Forty-five minutes later, the maintenance person and the on call manager were contacted. Fifteen minutes later, the administrator was contacted and arrived at the home to conduct a walk through of the home to determine if the source of the odour could be located. It was suspected that the source of the gas-like smell was from the heated air blowing into one of two main corridors and two separate RTAMUs were shut

down. The maintenance person arrived after the administrator and checked the RTAMUs and fire places. The maintenance person reported that a visual inspection was conducted, and that no meters were used to verify the presence of any compound, such as carbon monoxide. Not finding any visual clues, the maintenance person turned the RTAMUs back on. The maintenance person contacted their licensed/certified HVAC contractor the following day to schedule a visit. No further action was taken. The maintenance person was not a certified heating/ventilation mechanic.

During the first day of inspection, carbon monoxide detectors were not observed in the main lounge or the dining room, where gas appliances were located. The maintenance person acknowledged that they did not have any. According to a fire prevention officer from the local fire department, the detectors were a mandatory requirement and were required in adjacent rooms as well. Fire inspectors visited the home following Inspector #120 and confirmed that carbon monoxide detectors were installed in the appropriate areas on January 4, 2018.

As the licensee did not have a written emergency plan for gas leaks, the expected direction related to gas leaks was reviewed with various staff members of the home. The responses from registered staff for such an incident required that a call to the maintenance person or "9-1-1" be made. There was some confusion as to when to call "9-1-1" and exactly what steps needed to be taken by staff from different departments while waiting for emergency services to respond. There was no information written in the home's emergency plans or elsewhere regarding carbon monoxide sources in the home, the symptoms associated with exposure, methods to detect the gas and how to respond to evidence of a possible carbon monoxide leak.

According to registered and non registered staff, gas-like odours were noted intermittently when the gas fire places were first ignited as a source of supplemental heat on a specified date in the fall of 2017. During the inspection, the gas fire place in the main lounge was not operational and the maintenance person stated that a part needed to be replaced and was shut down approximately two days later. An expected date of repair could not be provided. Staff did not report that they had experienced any symptoms when they smelled the gas-like odours.

The lack of immediate action and a coordinated response from staff, registered staff and managers placed all of the building occupants in an unsafe environment related to carbon monoxide gas. [s. 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 is a safe environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines. O. Reg. 79/10, s. 26 (3).
2. Cognition ability. O. Reg. 79/10, s. 26 (3).
3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).
4. Vision. O. Reg. 79/10, s. 26 (3).
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).
6. Psychological well-being. O. Reg. 79/10, s. 26 (3).
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).
9. Disease diagnosis. O. Reg. 79/10, s. 26 (3).
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).
11. Seasonal risk relating to hot weather. O. Reg. 79/10, s. 26 (3).
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).
13. Nutritional status, including height, weight and any risks relating to nutrition care. O. Reg. 79/10, s. 26 (3).
14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).
16. Activity patterns and pursuits. O. Reg. 79/10, s. 26 (3).
17. Drugs and treatments. O. Reg. 79/10, s. 26 (3).
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).
19. Safety risks. O. Reg. 79/10, s. 26 (3).
20. Nausea and vomiting. O. Reg. 79/10, s. 26 (3).
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).
22. Cultural, spiritual and religious preferences and age-related needs and preferences. O. Reg. 79/10, s. 26 (3).
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care was based on, at a minimum, an interdisciplinary assessment of the following with respect to the resident: 11. Seasonal risk relating to hot weather.

A family member complained that resident #010 was suffering from heat stress in the summer months of 2016. Some of their concerns included staff not closing the curtains to keep the sun out, not using the fan provided, dressing the resident in inappropriate clothing for the temperature in the room and not providing sufficient fluids to maintain hydration.

A heat risk assessment was completed in 2017, which identified that resident #010 was at risk for heat related symptoms. The resident's written plan of care, which was required to provide clear direction for all nursing staff in the provision of all aspects of care, did not include the results of the heat risk assessment and specific interventions identified by registered staff or other interdisciplinary staff. Instead, the written plan of care included the goals and interventions that the resident's substitute decision maker requested be included. One particular goal included that the resident would remain comfortable and free from signs of distress related to the heat. Specific interventions were added to the plan in 2016, related to monitoring the resident for sings of heat stress. Under a separate section of the plan, another goal included a list of specific interventions for the resident in 2017 related to comfort.

During the clinical record review, two residents (#020 and #030) who were identified to have been admitted to the home in 2017, who did not have a heat risk assessment completed and the written plan of care for both residents did not have an interdisciplinary assessment of their seasonal risk related to hot weather. The Director of Care acknowledged that based on the electronic record system, it appeared that neither the heat assessments or written plan of care were completed. The Director of Care stated that it was an expectation that the registered staff complete a seasonal risk assessment related to hot weather and include the goals and interventions in the resident's written plan of care.

Interventions typical for residents in environments where rooms are not air conditioned or cooled, include but are not limited to environmental controls (appropriate window coverings to keep the heat out, sufficient ventilation, air temperature monitoring), frequent monitoring of the resident (for signs of heat stress), body temperature cooling

strategies, hydration strategies, appropriate clothing and bedding, re-location to cooling areas throughout the day, and if possible, the installation of a portable air conditioning unit. [s. 26. (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 the plan of care is based, at a minimum, an interdisciplinary assessment of seasonal risk relating to hot weather, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee did not ensure that the home was maintained at a minimum of 22 degrees Celsius.

On the first day of inspection, the indoor ambient air temperatures were verified by using a digital thermometer in various locations throughout the home. The outdoor air temperature was an average of -10 degrees Celsius (C).

1. A common space used by residents was observed to have a window air conditioner with cold outdoor air blowing into the room. A portable space heater was also seen near the window stored on the floor. According to maintenance request records, a staff member made a request in November 2017, to turn on the gas fire place in the main lounge because "everyone was cold". The common space was located next to the main lounge and was separated partially by a wall which housed the fire place. On two other specified dates in the fall of 2017, the maintenance request records included a request from staff that the common space air conditioner be removed. During the first date of inspection, staff commented on the cool temperatures in the room. A thermometer was placed next to an interior wall, at the furthest point from the air conditioner in the common

space for approximately one hour. A temperature of 20C was recorded. The administrator was informed on the same date and by the following day, the air conditioner was removed and the ambient air temperature increased to 22C.

2. One of the two main corridors in the home included a standard ambient air thermometer (using coloured alcohol as the thermometric substance) which was observed hanging on a wall near a resident bedroom. The thermometer display was 19.5C on both dates of the inspection. The fresh air supply blowing into one particular resident room was recorded using a digital laser thermometer and was approximately 14.4C. The air supply blowing into another resident room was approximately 20.4C.

3. The shower room located in the one of the two main corridors in the home was not equipped with any heat sources to heat the room with the exception of a heat lamp in the ceiling. On the second day of inspection, the heat lamp was not "on" while staff were taking residents into the room for showers. A PSW reported that it had been cold in the room for the residents. The Environmental Manager, after being informed about the lack of exhaust and heat in the room, reached up to the ceiling and tightened the bulb for the heat lamp, which subsequently lit up. A thermometer was left in the room with the heat lamp on, while unoccupied and the door closed for 45 minutes and was recorded at 21C.

4. Upon entry into the staff wing on the second day of inspection, cool air temperatures were immediately noticeable. The staff washroom was found to have one of two windows slightly ajar. The room was recorded with a thermometer for 30 minutes and was 16C. The electric baseboard heater was warm to the touch. Two windows were located in the room, one was observed to be missing a handle with which to latch the window closed and was slightly ajar. The second window was also missing a latch, but was screwed shut.

According to temperature records provided and interview with maintenance and nursing staff, air temperatures were monitored and recorded solely in the summer months and no records could be reviewed to determine if air temperatures were monitored throughout the year to ensure that a minimum of 22C was maintained. [s. 21.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee did not ensure that procedures were developed and implemented to ensure that the ventilation system was cleaned and in a good state of repair.

On the first day of inspection, the exhaust system (a component of the ventilation system) was checked after complaints were received from a resident and a visitor about offensive odours. A visual inspection was conducted of the exhaust vents in resident bathrooms, bedrooms and common areas. Most of the interior diffusers were heavily coated with dust in resident washrooms. The exhaust cover in the tub room was fully coated with dust. Although the rate of exhaust per cubic feet was not measured, confirmation as to whether any negative air movement was detected was conducted by using a piece of tissue held up against the exhaust vent grille. Seven identified resident washrooms, a shower room, medication room and housekeeping closet did not have any suction. The observed conditions were raised with the administrator on the first day of inspection, and on the following day, a contractor had been dispatched to evaluate the exhaust system. Service reports revealed that the ducting for the bathroom exhaust system had become disconnected, some components needed repair and some of the exhaust louvers were closed (instead of open). The exhaust system was repaired by the end of the inspection. The maintenance person was also observed cleaning the exhaust vents and internal louvers on the same day.

The licensee's maintenance policies and procedures were reviewed and no written procedures were developed that identified who would monitor and clean the ventilation and exhaust systems in the home, how often, what tasks were relegated to an external contractor versus the internal maintenance staff and what actions were to be taken if problems were identified. [s. 90. (2) (c)]

Issued on this 13th day of March, 2018

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

Original report signed by the inspector.