Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District
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Original Public Report

Report Issue Date: August 15, 2023	
Inspection Number: 2023-1117-0006	
Inspection Type: Complaint	
Licensee: peopleCare Communities Inc.	
Long Term Care Home and City: peopleCare Hilltop Manor Cambridge, Cambridge	
Lead Inspector Bernadette Susnik (120)	**Inspector Digital Signature** Bernadette Susnik Digitally signed by Bernadette Susnik Date: 2023.08.18 13:49:38 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 17, 18, 2023
The inspection occurred offsite on the following date(s): July 26, 2023, and August 1, 2023

The following intake(s) were inspected:

- Intake: #00091805 - Complaint regarding elevated air temperature and the condition of flooring in a resident room.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Safe and Secure Home
Infection Prevention and Control

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 356 (3) 2.

The licensee has failed to ensure that work on the home that significantly inconvenienced residents was not commenced without first receiving the approval of the Director.

A complaint was lodged regarding how the resident bedroom floor replacement process was managed. It was reported that the process was not well coordinated and rushed, and a resident was significantly inconvenienced by having to wait five hours longer than the allocated time that was communicated to complete the project.

During the inspection, a resident room was having the flooring replaced with uncontrolled ventilation methods. A large fan was placed on the floor and was blowing the dust generated from tile removal activities (which included dust from concrete) throughout the room. The room itself was being accessed throughout the day by contractors and the Director of Environmental Services (DES). The dust was permitted to spread outside of the zone of maintenance work. According to the DES, a total of four rooms had already received new flooring and nine more were scheduled.

No plans or specifications were submitted prior to the start of the project or available for review on July 17, 2023, describing how the work would be carried out, including how residents would be affected and what steps were to be taken to address any adverse effects on residents. The infection and prevention control lead for the home was not aware of the extent of the project and was not involved in assessing the type of work for air-borne infection related risks.

On July 18, 2023, the administrator provided a flooring project plan which included details of the project, dust mitigating strategies, timelines, the rooms which were to receive new flooring and how the residents would be managed.

Sources: Observation, interview with the Director of Environmental Services, Administrator, Director of Resident Care, Infection Prevention and Control Lead, review of existing renovation policies. [120]

Date Remedy Implemented: July 18, 2023

WRITTEN NOTIFICATION: Windows

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 19

The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents could not be opened more than 15 centimeters (cm).

Numerous large vertical sliding windows in resident bedrooms, some washrooms, dining rooms, lounges and corridors were not restricted to an opening of 15 centimeters. The hard vinyl face plates or strips (used to cover the opening into the sash pocket on both sides of the window which includes the pulley and chains) were removed to allow the windows to open greater than 15 cm to accommodate an exhaust hose and window opening cover panel for the upright portable air conditioners. The installation of the hose and a panel were loosely affixed to the perimeter of the open window frame with duct tape. The duct tape and panel could easily be removed from the window by anyone, allowing the window to be fully opened much beyond 15 cm. Many windows were also missing the hard vinyl face plates where no portable air conditioners were currently connected. No alterative window opening limiter device or hardware was installed in place of the face plates.

Failure to ensure windows are secured increases the risk of resident elopement from ground floor windows, or serious injury or death from upper floor windows.

Sources: Observations and test, interview with the Director of Environmental Services. [120]

WRITTEN NOTIFICATION: Lighting

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 21 1. i.

The licensee has failed to ensure that the lighting was maintained in accordance with the following requirements:

1. The lighting was maintained in a home to which a design manual, other than a manual from earlier than 2009, was applicable under a development agreement to which the home was subject in all corridors that had continuous consistent lighting throughout with minimum levels of 322.92 lux.

Rationale and Summary

The licensee added two floors and two wings in 2013 to their existing home, which had two floors and two wings. The licensee was subject to the lighting requirements of the 2009 Long Term Care Home Design Manual under their development agreement. The licensee was required to have a minimum of 322.92 lux for all of the corridors (hallways) added in 2013. Lux levels were below the required amount of 322.92 in the added corridors, which were equipped with semi-flush troffer style fluorescent lights. Measurements taken of the lighting fixtures on the 3rd and 4th floors in front of identified resident rooms were approximately 100 lux directly under the light fixtures in that area of the corridor and less than 100 lux when taken between the two fixtures. Some of the fixtures had been replaced in corridors, which were compliant with the minimum required lux, however the lighting remained inconsistent as there were dark and bright areas.

Failure to ensure adequate lighting can reduce a resident's ability to identify spaces, rooms, equipment, and signs and may contribute to accidents, particularly falls, and cause unnecessary stress (for example, being frightened by misinterpreting shadows).

Sources: Interview with the Environmental Services Manager, administrator, light measurements using a Sekonic Handy Lumi handheld light meter (held parallel to the floor at 32-34 inches above the floor) and observations. [120]

WRITTEN NOTIFICATION: Lighting

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 21 1. ii.

The licensee has failed to ensure that the lighting was maintained in accordance with the following requirements: the lighting was maintained in a home to which a design manual, other than a manual from earlier than 2009, was applicable under a development agreement to which the home was subject in all other areas of the home, including resident bedrooms and vestibules, washrooms and tub and shower rooms, with minimum levels of 322.92 lux.

Rationale and Summary

The licensee added two floors and two wings in 2013 to their existing home, which had two floors and two wings. The licensee was subject to the requirements of the 2009 Long Term Care Home Design Manual under their development agreement. The licensee was required to have a minimum of 322.92 lux in all areas of the home, including resident bedrooms, washrooms and tub and shower rooms when the new sections were added. Lux levels were measured in five different resident rooms which were equipped with semi-flush 12 to 14 inch round fluorescent ceiling lights with opaque lenses. Directly below these ceiling lights, the lux was 200-300, depending on how many bulbs were installed and operational. The rest of the room, which included areas that were more than 3 feet from the side or foot of the bed were over 100 lux below the requirement. The bedroom vestibules included a small LED recessed pot light that was 2 inches in diameter and could not emit light beyond its location. Directly below it, the light level was 100 lux. Beyond that, and along the path of travel to the resident's bed and washroom, the lux remained below 250.

The resident ensuite washrooms in two resident rooms were measured at the vanity and toilet areas. A light fixture or vanity light with three fluorescent or incandescent bulbs were provided over the sinks. The lux levels varied from 300 to 500 depending on the type of bulbs. The light however did not spread out much beyond the vanity area and the toilet area was 100 lux or less. This is despite some having a 2-inch diameter LED light above the toilet.

Failure to ensure adequate lighting can reduce a resident's ability to use washroom fixtures properly, identify spaces, rooms, equipment, furnishings, and signs and may contribute to

accidents, particularly falls, and cause unnecessary stress (for example, being frightened by misinterpreting shadows).

Sources: Interview with the Environmental Services Manager, light measurements using a Sekonic Handy Lumi handheld light meter (held parallel to the floor at 34 inches above the floor) and observations. [120]

WRITTEN NOTIFICATION: Plan of care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 11.

The licensee has failed to ensure that the plan of care for residents #001, #002 and #003 included protective measures required to prevent or mitigate heat related illness.

Rationale and Summary

Resident #001 and many other residents who were assessed as low risk for heat-related illness did not have any protective measures identified in their plan of care. This is despite the fact that all residents (especially if over the age of 65) are at some risk for heat-related illness, especially as the air temperatures reach 26°C. For residents #002 and #003, who were assessed as either moderate or high risk for heat related illness, the interventions in their plan of care were similar, despite each resident having different needs, medical diagnoses, and preferences. They both included general response measures which were clinical in nature; assess residents current health status and any signs and symptoms (whether related to medication use, or to the heat), provide fluids, alleviate discomfort with cool shower, sponge bath, change clothing and use of cooler areas of the building. Resident rooms are now required to be served by air conditioning equipment and therefore encouraging a resident to go to a cooler area of the building should no longer be necessary. No protective measures to prevent heat related illness (if and when necessary) were identified for either resident while in their rooms. Residents #001 and #003 had a portable air conditioner in their rooms, but this was not identified anywhere in the residents' care plan overall.

Environmental risk factors and specific interventions were not incorporated into the plan of care for residents #002 and #003 (although the risk factors are identified in the licensee's heat related illness prevention and management plan).

Failure to assess the resident's environment in addition to clinical risk factors and to subsequently include the protective measures in the plan of care for staff awareness may increase the resident's risk to heat-related illness.

Sources: Observations, interview with the Director of Resident Care, review of resident care plans, progress notes and heat risk assessments. [120]