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**
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

# Original Public Report

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| **Report Issue Date:** May 24, 2024 | |
| **Inspection Number:** 2024-1142-0003 | |
| **Inspection Type:** Complaint | |
| **Licensee:** 2063412 Ontario Limited as General Partner of 2063412 Investment LP | |
| **Long Term Care Home and City:** Creedan Valley Community, Creemore | |
| **Lead Inspector**<br>Bernadette Susnik (120) | **Inspector Digital Signature**<br>Bernadette Susnik Digitally signed by Bernadette Susnik Date: 2024.06.10 11:20:38 -04'00' |
| **Additional Inspector(s)** | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 14, 15, 2024
The inspection occurred offsite on the following date(s): May 16, 21, 2024

The following intake(s) were inspected:

- Intake: #00114106 - Anonymous complaint related to the hot water system in the building.

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

Housekeeping, Laundry, and Maintenance Services
Safe and Secure Home
Infection Prevention and Control

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Maintenance services

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)**
Maintenance services
s. 96 (1) As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance.

As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, the licensee failed to ensure that there were schedules and procedures in place for routine and preventive maintenance related to their mechanical exhaust ventilation and hot water systems.

**Rationale and Summary**
The licensee did not develop a procedure and associated schedule to ensure that their mechanical exhaust ventilation and hot water systems were maintained by conducting routine and preventative maintenance tasks in accordance with manufacturer's recommendations.

The licensee's preventive maintenance contract included a seasonal check of their exhaust ventilation motors on the roof. The contract did not include a check of any other components located inside the building, such as ducting, dampers, air registers and single exhaust fans in some resident washrooms. No written procedures were developed that included tasks for maintenance employees to follow and which tasks were to be left for a qualified technician.

The exhaust ventilation systems in the building were not functioning in multiple resident washrooms located in at least two different corridors on May 15, 2024. Two

identified resident ensuite washrooms had their own mechanical exhaust fans in the ceiling, one of which was rattling and was not extracting any air. A heating, ventilation, and air conditioning (HVAC) contractor was on site on May 16, 2024, to determine the cause of the lack of air flow and determined that the northeast wing did not have an exhaust motor installed and that the ducting that led to the roof was blocked. For other areas of the home, one motor on the roof was seized and another motor had no power. Maintenance staff of the home identified that occasional checks of the exhaust motors on the roof were completed, but no person checked the interior components and records were not provided to verify that the tasks were completed.

The domestic hot water system in the home included three hot water boilers and one hot water holding tank which were rented from an external company. According to the company, they were not hired to conduct yearly preventive maintenance checks on the tanks or the attached ventilation ducting. A visual inspection was only conducted when they were called in for a repair. The licensee's HVAC contractor confirmed that they did not preventatively inspect the hot water system or the attached ventilation ducting.

On October 8, 2023, one of the three hot water boilers had a small fire in the exhaust flue over the tank. A fire occurring in a flue is highly suggestive of excessive build-up of creosote or other combustion by-products, thereby creating a condition for combustion to occur. According to various manufacturers of hot water boilers, the exhaust flue is required to be checked annually for signs of build-up and obstructions and that it be cleaned regularly. No schedule, procedure or documentation was provided to determine if the boilers, tank, or exhaust ventilation was routinely, and preventatively maintained.

**Sources:** Interview with the Environmental Services Manager, maintenance assistant, Sienna Manager of Building Services, Executive Director, external contracted services, observations of the boilers and holding tank, review of boiler

rental records, manufacturer maintenance recommendations and contractor agreements and service reports. [120]

## WRITTEN NOTIFICATION: Maintenance services

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 96 (2) (i)**
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

The licensee did not ensure that procedures were developed and implemented to ensure the temperature of the hot water serving all bathtubs and showers used by residents was maintained at a temperature of at least 40 degrees Celsius.

**Rationale and Summary**
The licensee's hot water temperature monitoring policy directed registered nurses, tasked at taking hot water temperatures to monitor and record temperatures in tub rooms, resident bathrooms and public bathrooms on each shift. As the policy did not specify taking hot water temperatures of showers, staff did not monitor any in the home.

The temperature logs from January 10, 2024, to May 14, 2024, included the water temperature taken from an unspecified tub four times and none from the shower. The home had two tubs and one shower.

A staff member reported to the inspector that the hot water temperature serving the tubs was typically insufficient first thing in the morning, when water usage was high. The issue had been ongoing for many months. The staff member reported that the hot water temperature for the tub they normally used was approximately 38-40˚C

when they turned the water temperature control dial on the tub fully to the hottest setting and waited five minutes. Based on hot water temperature logs, the hot water temperature was recorded as follows;

Unspecified tub - 35˚C at 0600 hrs. on April 12, 204
Unspecified tub - 38˚C at 1400 hrs. on April 20, 2024
Tub #2 - 38˚C at 0600 hrs. on April 26, 2024

On May 14, 2024, both tubs (zone 2 and 3) were monitored for hot water temperatures. The temperature was 40 to 40.3˚C. It was noted that the hot water for the tub in zone 2 was lower than that of the hand wash basin (42.3 to 41.1C) despite the fact that both fixtures shared the same hot water pipe.

When the tub was monitored in zone 2 on May 15, 2024, the hot water temperature was below 40˚C based on the tub's digital display and when using a calibrated probe thermometer. The low tub water temperature therefore made it impossible for staff to temper the water to a resident's preference.

During the inspection, the shower hot water temperature was recorded to be approximately 38.8˚C on May 14, 2024, and 38.1˚C on May 15, 2024.

**Sources**: Review of Arjo tub manufacturer's specifications, water temperature logs, Water Temperature Monitoring Policy VII-H-10.50, interviews with care staff, Environmental Services Manager, maintenance assistant, Sienna Manager of Building Services, and measurements taken of the hot water. [120]

## WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)**
Infection prevention and control program

s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee failed to implement s. 7.3 (b) of the IPAC Standard (Sept. 2023) issued by the Director with respect to infection prevention and control related to ensuring that audits were performed regularly of all staff to ensure that they could perform the IPAC skills required of their role.

**Rationale and Summary**
The IPAC lead identified that they completed regular audits of staff related to hand hygiene, donning and doffing of personal protective equipment and the level of high touch surface disinfection (using a powder that glows when illuminated). However, they did not document which staff they audited or what their role was. No audits were conducted of laundry, activation, physiotherapy, dietary or housekeeping staff related to specific IPAC related activities performed by them in their roles.

**Sources**: Interview with the IPAC lead and review of existing audits. [120]

## WRITTEN NOTIFICATION: Reports re critical incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 115 (1) 1.**
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
1. An emergency within the meaning of section 268, including fire, unplanned evacuation or intake of evacuees.

The licensee failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances, of an emergency within the meaning of section 268, including fire, followed by the report required under subsection (5).

Under section 268 of O. Reg. 246/22, an "emergency" means an urgent or pressing situation or condition presenting an imminent threat to the health or well-being of residents and others attending the home that requires immediate action to ensure the safety of persons in the home.

**Rationale and Summary**
On October 8, 2023, the fire department was dispatched to the home to address a flue fire that had ignited over one of the home's three hot water boilers. The registered nurse on duty was informed by kitchen staff that smoke and flames were coming out of the flue just after 0600 hrs. The fire department arrived and dealt with the situation. The smoke was contained to the boiler room and service corridor and residents did not have to be evacuated. The licensee management staff working on October 8, 2023, did not inform the Director or submit a report.

**Sources:** Interview with dietary staff, a registered nurse, maintenance assistant, and review of emails and a service report from an external contractor. [120]

## COMPLIANCE ORDER CO #001 Maintenance services

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 96 (2) (g)**
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(g) the temperature of the water serving all bathtubs, showers, and hand basins

used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:** The licensee shall complete the following:

1. Amend the existing water temperature monitoring policy VII-H-10.50 to ensure that each tub and shower fixture are monitored at regularly scheduled intervals using a calibrated probe thermometer. The amended policy shall be reviewed with staff who take water temperatures, and the policy shall be implemented.

2. Amend and identify in the existing water temperature monitoring policy VII-H-10.50 the specific actions to be taken by resident care staff and maintenance staff to protect resident scalding when staff record water temperatures above 49˚C at hand wash basins located in resident accessible areas. The amended policy shall be reviewed with all staff and the policy shall be implemented.

3. The water temperature monitoring log shall include a written response that includes what actions were taken by staff when water temperatures were identified to be over 49˚C at resident accessible hand wash basins. The log shall be monitored by a designated manager regularly to ensure that it is fully completed.

4. Any electronic reports submitted by staff via the Maintenance Care system regarding the hot water system shall be responded to promptly and maintenance staff shall include a written response that includes what actions were taken, when and by whom.

5. Provide the inspector with a service report or documentation from a licensed plumber or other qualified person in regard to the hot water system that includes when the hot water system and associated plumbing was inspected to determine the root cause of the fluctuating hot water temperatures in the building. The service report shall be sent to the Inspector, Bernadette Susnik via email at CentralWestDistrict.MLTC@ontario.ca.

6. Develop a plan that summarizes what interventions or actions have been taken or those that are planned to ensure that the water temperatures serving tub and shower fixtures can be maintained at a minimum of 40˚C and that hand wash basins accessible to residents do not exceed 49˚C. The plan shall include the dates and the person(s) responsible for implementing any interventions or actions. The plan shall be sent to the Inspector, Bernadette Susnik via email at CentralWestDistrict.MLTC@ontario.ca

**Grounds**
The licensee did not ensure that procedures were implemented to ensure that the temperature of the water serving all hand basins used by residents did not exceed 49 degrees Celsius.

**Rationale and Summary**
The licensee's water temperature monitoring policy identified that the maintenance team were to adjust the hot water temperature when it exceeded 49˚C and that a contracted service provider would need to be contacted if a member of the team at the home could not resolve the issue themselves. The policy also included that the water temperature would need to be taken again once the adjustment or repairs were made to ensure the hot water temperature was within range (40-49˚C) and that team members and residents would need to be notified that normal procedures for use of the hot water system could resume. The policy included a statement that all team members were to be informed of the associated risks of

water use when outside the range and to take actions, but no specific risks or actions were included.

Water temperature logs between January 10, 2024, and May 14, 2024, included water temperature recordings between 50 and 60˚C in various resident ensuite washrooms on 54 different shifts. These exceedances were identified mostly on the night shift. The registered nurses, who were tasked at taking the readings, left the "comments" section on the water temperature log blank except for eleven of the identified exceedances. This column was to include what immediate actions they took. The maintenance response column was blank in each of the 54 instances. The licensee's maintenance software application used by staff to identify and report deficiencies was noted to include submissions by registered and non-registered staff to report some of the hot water temperature exceedances. The responses to the submissions by maintenance staff were either blank, included a note that the hot water system was being monitored, that the issue was acknowledged, or that a new water heater installation was pending.

Issues with hot water temperatures over 49˚C have been known to the licensee since October 6, 2023. The maintenance manager identified that they could not easily adjust hot water temperatures. Water temperature logs and care staff revealed that hot water temperatures were low in the mornings and very high at night when water was not being used. Despite the fact that the licensee replaced a hot water holding tank on April 5, 2024, and had repairs and rebuilds of their thermostatic mixing valve and other components in February 2024, the hot water continued to exceed 49˚C into May 2024.

Failure to control extreme fluctuations of the hot water system may cause resident injury, especially when staff have not implemented any immediate actions to deal with hot water when they discover that it is over 49˚C at resident accessible hand wash basins.

**Sources:** Reviewed contractor service reports and written contract for HVAC system, water temperature monitoring logs, emails, maintenance care software system reports, Water Temperature Monitoring policy VII-H-10.50, interviews with care staff, Environmental Services Manager, maintenance assistant, external contracted services, laundry, and kitchen staff and took water temperatures throughout the home. [120]

**This order must be complied with by** June 27, 2024

## REVIEW/APPEAL INFORMATION

**TAKE NOTICE**
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email

or commercial courier upon:

**Director**
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

**Health Services Appeal and Review Board**
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

**Director**
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.