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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Mar 19, 2018 | 2018_539120_0008 | 000019-18, 000050-18, 002836-18 | Complaint |

### Licensee/Titulaire de permis

Rykka Care Centres LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

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

Cooksville Care Centre
55 The Queensway West MISSISSAUGA ON L5B 1B5

### 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): February 14, 20, 2018**

**Three complaints were received (Intake #000019-18, #000050-18 and #002836-18) related to air temperatures in the home.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Environmental Services Supervisor, Director of Care, maintenance staff, registered staff, personal support workers (PSW) families and residents.**

**During the course of the inspection, the inspector toured the home, reviewed maintenance requisitions, maintenance policies and procedures, loss of heat emergency plan, observed heating units in multiple resident rooms, reviewed the complaint response process, resident clinical records and verified ambient air temperatures.**

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

**During the course of this inspection, Non-Compliances were issued.**
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 O.Reg 79/10, s. 230. Emergency plans**

**Specifically failed to comply with the following:**

**s. 230. (5) The licensee shall ensure that the emergency plans address the following components:**
**1. Plan activation. O. Reg. 79/10, s. 230 (5).**
**2. Lines of authority. O. Reg. 79/10, s. 230 (5).**
**3. Communications plan. O. Reg. 79/10, s. 230 (5).**
**4. Specific staff roles and responsibilities. O. Reg. 79/10, s. 230 (5).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the emergency plans addressed the following components related to the loss of one or more essential services:

1. Plan activation.
4. Specific staff roles and responsibilities

An essential service includes but is not limited to the provision of heat, and is required to be supplied by a generator if the heat fails due to a loss of hydro as described under section 19 of O. Reg 79/10, or if the heat fails due to mechanical issues or any other service disruption. Further, the licensee is required to ensure that the home is maintained at 22 degrees Celsius, as per O. Reg 79/10, s. 21.

According to the licensee's written emergency plan I-05-10 "Loss of Hydro (Loss of Essential Service)", revised June 28, 2017, the following would be enacted if there was a loss of hydro during cold weather: (1) all windows and exterior doors are closed, (2) obtain additional blankets from storage and use as necessary to keep residents warm, (3) keep vacant room doors closed to minimize loss of heat and (4) if temperatures drop to "unacceptable levels and/or the power supply cannot be restored for an extended period of time (more than three hours), initiate an evacuation.

With respect to plan activation, the emergency plan failed to identify what the unacceptable levels were before residents needed to be evacuated from affected areas or the building, or when the above listed actions would begin. With respect to staff roles and responsibilities, the plan failed to include the role of the maintenance staff and who would carry out specific actions related to the provision or maintenance of heat, whether related to loss of hydro or failure of the heating equipment.

Two separate complaints were received in December 2017, related to cold air temperatures in the home.The complainants had concerns about the actions that were not taken by various staff members at the time to ensure that the residents were kept warm and comfortable after one of two heating units failed in an identified room and where the second unit in the room had excessive leakage of cold air entering into the room from under the unit.

Outdoor air temperatures (According to Environment Canada for Oakville and Hamilton weather stations) were minus 17 degrees Celsius on several days in December 2017.

During the inspection, neither maintenance staff nor nursing staff were able to provide any documentation as to what the ambient air temperatures were in the identified resident room before, during or after the dates raised by the complainants. No thermometers had been placed in the room or actions taken to determine the air temperature in the room to ensure a minimum of 22C. Two registered staff members who worked in December 2017, reported that they were aware of the cool conditions in the resident room, but did not know at what temperature they needed to begin evacuating residents from the room. One registered staff member reported that they completed maintenance requisitions to have the heating units inspected, and both staff members reported that they had access to portable heaters and extra blankets, and had vacant rooms in which to re-locate residents if the residents chose to relocate. No verification was made as to whether the portable heaters that were installed in the various rooms on the first floor were able to maintain air temperatures at 22C.

According to one complainant, they brought in a portable heater for use in an identified resident room in December 2017, and stated that the heater was not able to heat the room adequately and despite the additional blankets provided to the resident, the resident was not comfortable and was offered and accepted a different room in which to sleep for the night.

Documentation was provided that confirmed that maintenance requests were completed by staff for various heating units, which were identified as not working properly and that cold air was blowing into resident rooms. One particular request was completed by a Registered Nurse (RN), who documented that cold air was blowing into most of the rooms (but did not identify which rooms and on what floor). The RN verified that the request was made in relation to approximately five rooms on one particular floor of the home. On another date in January 2018, another maintenance request was made identifying that two rooms on the same floor were "very cold", that cold air was blowing in and there was minimal heat emanating from the heaters in the rooms. According to maintenance records and maintenance staff, several heating units were repaired and others were insulated to prevent cold air from seeping in under the units. Maintenance staff did not take any air temperatures of any room to determine if the rooms were maintained at a minimum of 22C.

The emergency plan related to a loss of heat therefore did not include an activation component that specifically outlined when staff would begin taking actions. The specific staff roles and responsibilities for determining air temperatures, maintaining air

temperatures at 22C, monitoring residents for signs of hypothermia, the safe use of portable heaters and how to acquire them, and the actions needed to be taken should an insufficient amount of portable heaters be available to manage large areas or multiple areas (if multiple rooms had failed heaters or if common areas were affected) were not included in the loss of essential services emergency plan. [s. 230. (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 emergency plans addressed the following components related to one or more essential services; 1. Plan activation and 4. Specific staff roles and responsibilities, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

According to the written plan of care for an identified resident, the resident had several physical and cognitive limitations that required total staff assistance for all activities of daily living. For interventions associated with the resident's comfort, the plan included direction that care staff would ensure that the resident's room was maintained at 24C. The intervention was added to the plan of care following air temperature concerns that were raised by the Substitute Decision Maker (SDM) for the resident in the winter months of 2018. However, according to written documents kept by the registered staff, and other evidence, the room temperature was not kept at 24C (or within the range of 24C) on a specified date in 2018, which prompted the SDM to contact the Ministry of Health and Long Term Care.

A complaint from the resident's SDM was forwarded to registered staff on a specified date in 2018, that the resident was observed to have exhibited signs of discomfort related to excessive heat in their room. During the SDMs visits, on several separate occasions, they identified that the registered staff did not take actions to alleviate the resident's symptoms of discomfort until they were requested to do so. The SDM approached one of the home's managers to try and resolve their concerns. An intervention that was implemented included shift to shift air temperature monitoring by registered staff. After the intervention was implemented, the SDM reported that they continued to find issues during their visits, especially on a particular shift. One week later, in response to additional complaints to the registered staff about excessive heat in the room, a maintenance staff member applied a lock on the heater control panel that was located in the room. The temperature settings were therefore under the control of the registered staff and who were responsible to maintain the room at a comfortable temperature for both residents in the room. The specific comfortable temperature that was decided upon between the co-resident and SDM was 24C. Several days later, the SDM was at the resident's bedside and expressed concerns to registered staff that the room was too hot. The following day, the SDM noted that the room was very hot and observed that the resident exhibited signs of discomfort and no actions had been taken to alleviate the resident's symptoms. A thermometer located in the resident's room, according to the SDM, was 28-30C. When the SDM informed the RN about the heat, they could not find the key to unlock the heater control panel. The RN left their shift before resolving the issue and the oncoming RN did not take any action until the SDM approached them several hours later that the resident's room was too hot and that the resident was uncomfortable. The RN could not find the key initially, and had to get assistance from maintenance staff to locate the key. Once located, the heater temperature was re-set, however the RN could not remember what the temperature of the heater was set to.

During the inspection, the ambient air temperature was 25C based on a thermometer found on a wall near the resident. According to progress notes made for the resident by various registered staff members from different shifts, air temperatures were taken and documented, and no temperature over 27C was noted, on any shift since temperatures were first recorded. The RN was asked how the air temperatures were taken and monitored in the resident's room. The RN provided an infrared forehead thermometer, with a "room" temperature mode. According to the manufacturer's information for the thermometer, the thermometer was not capable of taking the ambient air temperature, but of a surface only. Therefore, depending on what surface the thermometer was aimed at, each person taking the temperature, would have gotten a different temperature, as

different surfaces have different temperatures. The temperatures taken and documented by the RNs could therefore not be used to determine if the room was adequately monitored for comfort.

Progress notes included confirmation by several different RNs that the resident had shown signs of discomfort on three different dates in 2018. Details included how the resident was found and what interventions were removed or applied by both registered staff and the SDM. According to the SDM, the interventions were applied to alleviate the symptoms the resident exhibited. Discussion with the SDM and management staff was held during the inspection and the resident was re-located away from the heater within the room several days later.

A combination of the resident's medical condition, room temperatures and application of specific interventions appeared to have contributed to the resident's signs of discomfort. The nursing staff failed to ensure that the settings on the heating unit in the room were set accordingly and that ambient air temperatures using appropriate equipment was installed and used to measure the ambient air temperatures to provide a comfortable environment for the resident, as per the plan of care. [s. 6. (7)]

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**Issued on this 9th day of April, 2018**

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

**Original report signed by the inspector.**