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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: July 6, 2023

Inspection Number: 2023-1106-0002

Inspection Type:
District Initiated
Complaint
Critical Incident System

Licensee: Revera Long Term Care Inc.

Long Term Care Home and City: Oak Terrace, Orillia

Lead Inspector	**Inspector Digital Signature**
Charlotte Scott (000695)	Charlotte A Scott Digitally signed by Charlotte A Scott Date: 2023.07.14 12:03:32 -04'00'

Additional Inspector(s)
Karen Hill (704609)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 20-22, 2023.

The following intake(s) were completed:

- Intake: #00018440 related to incident causing injury to a resident.
- Intake: #00087905 complaint related to infection prevention and control (IPAC) and air temperature.
- Intake: #00088459 related to air conditioning requirements.
- Intake #00002641 related to falls prevention and management, and;
- Intake #00002931 related to falls prevention and management.

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

Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Cooling Requirements

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 23 (4) (b)

The licensee has failed to ensure that the heat related illness (HRI) prevention and management plan for the home was implemented when the temperature in an area of the home, measured by the licensee in accordance with subsections 24 (2) and (3) reached 26 degrees Celsius or above, for the remainder of the day and the following day.

Rationale and Summary
A complaint was received by the Ministry of Long-Term Care regarding elevated air temperatures in the home prior to May 15, 2023.

The licensee's HRI procedure indicated that the home's "Heat Response Plan" was to be implemented each year between May 15 to September 15, and at any other time the internal temperatures and/or external temperatures forecasted by Environment and Climate Change Canada, for the area which the home was located, were 26 degrees Celsius or above.

On five consecutive dates prior to May 15, 2023, Environment and Climate Change Canada, reported temperatures where the home was located, above 26 degrees Celsius. Review of the home's temperature logs and the hourly temperature reports for the same timeframe, indicated that air temperatures in several of the home areas and resident rooms, were also 26 degrees Celsius and above, for consecutive days.

The Executive Director (ED) acknowledged that during the identified dates, the Environmental Service (ES) Manager would have been aware of the elevated temperatures throughout the home and in resident rooms but did not report or act upon the elevated temperatures as required. Registered staff acknowledged that when they became aware of the elevated temperatures in the home, they should have assessed the residents for HRI and did not. The Director of Care (DOC) and the ED both confirmed that HRI assessments and implementation of the HRI plan should have been done whenever the air temperatures read 26 degrees Celsius or above, in the home and were not.

Failing to ensure that the HRI was implemented on every day and the following day, when the temperatures inside and outside of the home were greater than 26 degrees Celsius, placed the residents

in the home at potential risk for heat related illness.

Sources: Licensee's HRI plan: Procedure CARE10-O10.09, last reviewed March 31, 2023; Interdisciplinary Heat Response Plan, CARE10-O10.09-T7; Heat Stress Alert Poster, CARE10-O10.09-T4; Second floor temperature logs; home's temperature report, hourly elevated temperatures; Environment and Climate Change Canada, temperatures for Orillia, Ontario; clinical health records for residents; home's response letter to complainant; home's written notes outlining response to elevated temperatures; and interviews with Personal Support Worker (PSW) staff and registered staff, Interim ES Manager, Staff Educator, DOC, and ED.
[704609]

WRITTEN NOTIFICATION: Infection Prevention and Control Practices

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to IPAC was implemented.

Specifically, the licensee did not ensure staff donned appropriate personal protective equipment (PPE) required when providing care to a resident identified under additional precautions as is required by Additional Requirement 9.1 (f) under the IPAC Standard.

Rationale and Summary
During the inspection, signage was observed on the door of a resident's room, indicating additional precautions were in place. Staff were observed entering the resident's room without donning the PPE as indicated on the sign. The staff indicated that they should have donned the required PPE when entering the resident's room to provide care and did not.

Failing to don the required PPE when providing care to a resident identified under additional precautions placed residents in the home at potential risk of infection.

Sources: Inspector observations; licensee policy titled Routine Practices and Additional Precautions Contact Precautions last reviewed: March 31, 2023, licensee policy titled Routine Practices and Additional Precautions Droplet Precautions last reviewed: March 31, 2023; Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes April 2022; interviews with PSW staff and registered staff.
[000695]

WRITTEN NOTIFICATION: Air Conditioning Requirements

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 23.1 (2)

The licensee has failed to ensure that air conditioning was installed, operational, and in good working order in every resident bedroom and every designated cooling area, in the home (a) on any day on which the outside temperature forecasted by Environment and Climate Change Canada for the area in which the home was located was 26 degrees Celsius or above at any point during the day; and (b) any time the temperature in the home measured by the licensee in accordance with subsections 24 (2) and (3) reached 26 degrees Celsius or above, for the remainder of the day and the following day.

Rationale and Summary
A complaint was received by the Ministry of Long-Term Care regarding elevated temperatures in the Long-Term Care (LTC) Home, prior to May 15, 2023.

On five consecutive dates, prior to May 15, 2023, Environment and Climate Change Canada reported temperatures in Orillia of 26 degrees Celsius and above. The LTC home's hourly temperature reports also revealed internal temperatures of 26 degrees Celsius and above for consecutive days. Interviews with staff and a review of the home's written records of actions taken in response to the complaint about the elevated temperatures, revealed that the home's usual interventions for hot weather had not yet been initiated and that air conditioning units were not installed in resident rooms until several weeks following the initial elevated temperatures.

There was an increased risk of heat related illness for residents when the licensee failed to ensure that air conditioning was installed, operational and in good working order, when the temperature in areas of the home measured by the licensee and reported by Environment and Climate Change Canada, reached 26 degrees and above.

Sources: The home's temperature report, hourly elevated temperatures; Environment and Climate Change Canada, temperatures for Orillia, Ontario; home's response letter to complainant; home's written notes outlining response to elevated temperatures; and interviews with registered staff, Interim ES Manager, Staff Educator, and ED.
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