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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 11, 2015	2015_396103_0057	O-032455-15	Complaint

Licensee/Titulaire de permis

TRENT VALLEY LODGE LIMITED
195 Bay Street TRENTON ON K8V 1H6

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

TRENT VALLEY LODGE LIMITED
195 BAY STREET TRENTON ON K8V 1H9

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

DARLENE MURPHY (103)

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): December 9-10, 2015.

During the course of the inspection, the inspector(s) spoke with residents, Personal support workers (PSW), Registered Practical Nurses (RPN), a Registered Nurse (RN), the Maintenance worker, and the Director of Care (DOC).

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

During the course of this inspection, Non-Compliances were issued.

2 WN(s)
0 VPC(s)
1 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 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,
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius; O. Reg. 79/10, s. 90 (2).

s. 90. (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; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure immediate action was taken to reduce the water temperature when it exceeded 49 degrees Celsius.

The home's water temperature records were reviewed from November 3 to December 9, 2015. Water temperatures greater than 49 degrees Celsius were recorded on the following dates in resident rooms:
Third floor- November 3, 4, 5, 9, 12, 14, 16, 17, 18, 19, 23, 24, 25, December 2, 4, 6, 7; the temperatures ranged between 50.1- 58.9 degrees Celsius and occurred on evening and night shifts.
Second floor- November 3, 5, 10, 11, 13, 15, 16, 18, 19, 22, 24, 26, 28, December 1, 2, 3; the temperatures ranged between 50.0- 56.9 degrees Celsius and occurred on evening and night shifts.
First floor- November 3- 19, December 9; the temperatures ranged between 51.0- 57.1 degrees Celsius and occurred on all three shifts.

RPN's #103 and #109 were interviewed and were asked to describe what actions are taken when the water temperatures are found to be higher than 49 degrees Celsius. Both of the RPN's interviewed stated most of the high temperatures are identified on evenings and nights when maintenance is not on site. All indicated maintenance is notified by leaving a message on their voice mail which is retrieved the following day.

The staff also stated they have been told on several occasions that the higher water temperatures are to be expected on the evening and night shifts and therefore nothing is done to correct it. During the review of the documented water temperatures, it was noted there was no documentation to reflect when maintenance was notified and if any actions had been taken to correct the increased water temperatures.

Maintenance worker #100 was interviewed and stated most staff notify him by means of a voice mail message when the water temperatures are found to be above the normal range which he retrieves the following working day. #100 also stated the higher water temperatures on the evening and night shifts are normal due to the decreased demand for hot water on those shifts. He further stated the home has two separate hot water systems: one that supplies hot water to the basement and the first resident floor and the second that supplies hot water to the second and third resident floors.

On December 9, 2015, this inspector utilized the home's thermometer and recorded three random water temperatures on the first floor:
1300 hr-Identified resident room #1-53.2 degrees Celsius,
1310 hr-Identified resident room #2-53.4 degrees Celsius
1330 hr-Tub room sink-53.4 degrees Celsius.

RPN's #103, #107 and #109 were interviewed in regards to what, if any, instructions they are given related to the necessary actions that need to be taken when the water temperatures are above the acceptable range. All of the staff interviewed stated they have never been advised to take any additional actions and have never relayed any instructions to the staff they work with to alert them about the higher water temperatures.

The home's policy, "Water Temperature Monitoring", VII-H-10.26 was reviewed.
Under Procedure, it states the RN/RPN:
-should notify the Maintenance Personnel for adjustment and appropriate intervention and document all reports and follow up in the "comments" column of the monitoring form.
-should the maintenance personnel not be available, contact the Director of Support Services or the Director of Care or the Administrator in that order.
Instruct all staff of the associated risks involved for the use of water outside the range specified and what actions to take in the event of such an occurrence.

The DOC was interviewed and stated it has been the accepted practice to leave a voice mail for the Environmental Manager (who recently left the home) or the Maintenance man when the water temperatures are not within the acceptable range. In addition, the

DOC stated staff members have not been instructed on the precautions that should be instituted when the water temperatures exceed the acceptable range.

The severity of elevated water temperature was assessed. Water temperatures that exceed 49 degrees Celsius pose a potential risk to residents from hot water scalding. The home has no current practice in place to notify staff or residents when this risk is heightened. The scope of the risk is widespread as it affects all residents and is especially a risk for residents who can independently use the bathroom facilities without being made aware of the higher water temperatures. Due to the scope and severity of this risk, a compliance order is being issued. [s. 90. (2) (h)]

2. The licensee has failed to ensure the temperature of the hot water serving all bath tubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius.

The water temperatures were reviewed from November 3 to December 9, 2015. The following dates were found to have tub temperatures of less than 40 degrees Celsius:

First floor- November 22, 26, 30, December 1, 7; all were identified on the evening shift except for November 22 which occurred on the day shift. The temperatures ranged from 36.1 to 38.5 degrees Celsius.
Second floor-November 3, 5, 6, 7, 9, 19, December 5, 8, 9; all were identified on the day and evening shifts. The temperatures ranged from 31.2 -39.5 degrees Celsius.
Third floor- November 14, 24, 28, December 1, 8, 9; all were identified on the day and evening shifts. The temperatures ranged from 22.0- 39.2 degrees Celsius.

On December 9, 2015, this inspector used the home's thermometers to check three random locations on the second and third floors and found the following:
1210 hr Identified Second floor resident room #1- 47.0 then would drop to 23.1 degrees Celsius,
1220 hr Identified Second floor resident room #2-46.8 then would drop to 34.5 degrees Celsius,
1240 hr tub room sink on second floor- 42.1 degrees Celsius.

1130 hr Identified Third floor resident room #1-40.2 then would drop to 35.5 degrees Celsius,
1145 hr-third floor tub room sink-25.9 degrees Celsius,
1250 hr-Identified Third floor resident room #2-33.5 degrees Celsius.

PSWs #101, 102, 105 and 106 were interviewed. All of the staff reported being unable to complete tub baths over the past two to three days due to a lack of hot water. They described being able to get only a couple of inches of warm water in the tub and then the water would become cold. Staff stated the water in the resident bathroom sinks start to become warm and then suddenly become cold again. All stated the residents are being offered bed baths using ready bath kits that are microwaveable in an attempt to provide the residents with a bathing option. The staff members stated the home has been having issues related to water temperatures on and off over the past month and residents are frustrated. All staff expressed they have not received any communication in regards to the lack of hot water or when the problem may be rectified.

Residents #001, #002, #003 and #004 were interviewed and did express their frustration with being unable to have their scheduled tub baths. The residents stated they felt the staff were doing the best they could, but did not feel they were updated in regards to when the problem would be fixed. The residents also stated the issue has been ongoing over the past one to two months.

The maintenance records related to the hot water supply were requested and reviewed. This inspector noted that during the months of March and April 2015, the home requested service calls for having inadequate supplies of hot water to the second and third floors. No service records were found from November 1 to December 9, 2015 to address the current hot water supply issues. [s. 90. (2) (i)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure the Director was notified no later than one business day after the occurence of the breakdown of a system in the home.

On December 9, 2015, the Maintenance worker #100 was interviewed and stated the home has been having problems supplying the home with adequate hot water over the past three to four weeks. According to #100, hot water tank #1 required a new sensor and hot water tank #2 required a new fan motor. He advised the parts were on order.

To date of this inspection, the home had not informed the Director of the breakdown of the system that supplies hot water to the residents throughout the home. [s. 107. (3) 2. ii.]

Issued on this 11th day of December, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARLENE MURPHY (103)
Inspection No. / No de l'inspection :	2015_396103_0057
Log No. / Registre no:	O-032455-15
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 11, 2015
Licensee / Titulaire de permis :	TRENT VALLEY LODGE LIMITED 195 Bay Street, TRENTON, ON, K8V-1H6
LTC Home / Foyer de SLD :	TRENT VALLEY LODGE LIMITED 195 BAY STREET, TRENTON, ON, K8V-1H9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	BILL WEAVER JR

To TRENT VALLEY LODGE LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(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;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(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;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(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;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee is hereby ordered to comply with O. Reg 79/10, s. 90 (2) (h) and s. 90 (2) (i) by updating the home's policy, "Water Temperature Monitoring", VII-H-10.26 to include:

-how notifications by the registered nursing staff will be made to the specified personnel such that immediate action can be taken to address water temperatures outside of the acceptable range,

-the required documentation by the registered nursing staff of the time the specified personnel was notified,

-the specific actions that will be immediately instituted by the registered nursing staff to ensure resident safety when water temperatures exceed the acceptable range,

-the specific actions that will be taken when tub baths and showers cannot be completed due to low water temperatures,

-how and where the specified personnel, who are designated as responsible for addressing water temperatures outside of the acceptable range, will document all actions taken and the time the action was taken.

Education will be provided to all registered nursing staff and all personnel identified as responsible for addressing water temperatures outside of the acceptable range to ensure full implementation of the policy.

Grounds / Motifs :

1. The licensee failed to ensure immediate action was taken to reduce the water temperature when it exceeded 49 degrees Celsius.

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RPN's #103 and #109 were interviewed and were asked to describe what actions are taken when the water temperatures are found to be higher than 49

degrees Celsius. Both of the RPN's interviewed stated most of the high temperatures are identified on evenings and nights when maintenance is not on site. All indicated maintenance is notified by leaving a message on their voice mail which is retrieved the following day. The staff also stated they have been told on several occasions that the higher water temperatures are to be expected on the evening and night shifts and therefore nothing is done to correct it. During the review of the documented water temperatures, it was noted there was no documentation to reflect when maintenance was notified and if any actions had been taken to correct the increased water temperatures.

Maintenance worker #100 was interviewed and stated most staff notify him by means of a voice mail message when the water temperatures are found to be above the normal range which he retrieves the following working day. #100 also stated the higher water temperatures on the evening and night shifts are normal due to the decreased demand for hot water on those shifts. He further stated the home has two separate hot water systems: one that supplies hot water to the basement and the first resident floor and the second that supplies hot water to the second and third resident floors.

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The home's policy, "Water Temperature Monitoring", VII-H-10.26 was reviewed. Under Procedure, it states the RN/RPN:
-should notify the Maintenance Personnel for adjustment and appropriate intervention and document all reports and follow up in the "comments" column of the monitoring form.
-should the maintenance personnel not be available, contact the Director of Support Services or the Director of Care or the Administrator in that order.

Instruct all staff of the associated risks involved for the use of water outside the range specified and what actions to take in the event of such an occurrence.

The DOC was interviewed and stated it has been the accepted practice to leave a voice mail for the Environmental Manager (who recently left the home) or the Maintenance man when the water temperatures are not within the acceptable range. In addition, the DOC stated staff members have not been instructed on the precautions that should be instituted when the water temperatures exceed the acceptable range.

The severity of elevated water temperature was assessed. Water temperatures that exceed 49 degrees Celsius pose a potential risk to residents from hot water scalding. The home has no current practice in place to notify staff or residents when this risk is heightened. The scope of the risk is widespread as it affects all residents and is especially a risk for residents who can independently use the bathroom facilities without being made aware of the higher water temperatures. Due to the scope and severity of this risk, a compliance order is being issued.

(103)

2. The licensee has failed to ensure the temperature of the hot water serving all bath tubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius.

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PSWs #101, 102, 105 and 106 were interviewed. All of the staff reported being unable to complete tub baths over the past two to three days due to a lack of hot water. They described being able to get only a couple of inches of warm water in the tub and then the water would become cold. Staff stated the water in the resident bathroom sinks start to become warm and then suddenly become cold again. All stated the residents are being offered bed baths using ready bath kits that are microwaveable in an attempt to provide the residents with a bathing option. The staff members stated the home has been having issues related to water temperatures on and off over the past month and residents are frustrated. All staff expressed they have not received any communication in regards to the lack of hot water or when the problem may be rectified.

Residents #001, #002, #003 and #004 were interviewed and did express their frustration with being unable to have their scheduled tub baths. The residents stated they felt the staff were doing the best they could, but did not feel they were updated in regards to when the problem would be fixed. The residents also stated the issue has been ongoing over the past one to two months.

The maintenance records related to the hot water supply were requested and reviewed. This inspector noted that during the months of March and April 2015, the home requested service calls for having inadequate supplies of hot water to the second and third floors. No service records were found from November 1 to December 9, 2015 to address the current hot water supply issues.

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 23, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 11th day of December, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DARLENE MURPHY

Service Area Office /
Bureau régional de services : Ottawa Service Area Office