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 sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 28, 2016	2016_346133_0016	010624-16	Complaint

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Trillium Retirement and Care Community
800 EDGAR STREET KINGSTON ON K7M 8S4

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

JESSICA LAPENSEE (133)

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): April 11-13, 15, 18-19 - 2016

This Complaint Inspection is related to a complaint regarding maintenance related issues.

This complaint inspection began during stage 2 of the Resident Quality Inspection (RQI, #2016_347197_0008, April 4-8 and 11-18, 2016) and continued following the completion of the RQI.

During the course of the inspection, the inspector(s) spoke with The Administrator, the Maintenance and Building Services Manager, Maintenance staff, Registered and Non Registered nursing staff, the Associate Director of Care for the Court building and Physiotherapy staff.

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)**
- **2 VPC(s)**
- **0 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 LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 15 (2) (c) in that the licensee has failed to ensure that the home is maintained in a safe condition and in a good state of repair.

This finding of non-compliance is specifically related to hallway flooring throughout the Ridge building.

On April 12th, 2016, in the immediate area of the Cottage fire door and bedroom #227, the Inspector detected a notably depressed area in the floor. There was a tear in the linoleum that was approximately four and a half inches in length, approximately 21.5 inches out from the wall mounted Purell dispenser, between the fire door and bedroom #227. The subsurface was best described as very soft and spongy. The depressed area was approximately the size of a softball. The Inspector's thick square block heel fit into the depression. The Inspector also observed that there was red Tuck Tape along some floor seams in the area of nearby bedroom #233.

On April 13th, 2016, in the centre of the hallway, between bedrooms #203 and #201, out from the middle of the handrail between the rooms, the Inspector noted another area of depression. The linoleum above the soft and spongy area was intact. The area was approximately the same size of the previously described area, but it was not quite as deep. Staff passing by the inspector at the time of this observation remarked that there were many similar areas throughout the building.

On April 18th, 2016, in the immediate area of the Orchard unit stairway door, approximately 27 inches out from the corner wall, going towards bedroom #223, the inspector noted another area of depression. There were two tears in the linoleum in one section of the depressed area. The area was approximately one and a half inches wide and 11 inches in length. The subsurface immediately beneath the tears was the softest. While making notes about this, the Inspector observed a resident with heeled shoes walking around the area, resident #001.

The Maintenance and Building Services Manager (MBSM) met the Inspector while the area described above was being observed. He indicated that he was aware of the issue, and explained the reason for it. The floor was redone 10 – 12 years ago, and an inappropriate subsurface was used. That is, beneath the linoleum surface there is a gypsum subsurface, and it is degrading. He explained that one reason for the

degradation is that in some areas, floor seam welds have released, such as in the area of bedroom #233, and in other areas, the linoleum surface has been damaged, and this has allowed water to penetrate the gypsum. He explained that in general, the gypsum is failing, at uneven rates, throughout the building, and this is causing the depressions and the visible ridges (along the gypsum seams) down the hallways. Related to the depression at the Cottage fire door, he indicated that the plywood beneath the gypsum was also likely damaged, given how soft the depressed area was. The MBSM acknowledged that there are many such depressions, noting that many are more subtle than what has been described above.

The MBSM explained that in response to this issue, they had replaced a strip of flooring that had been considered to be one of the worst, at the fire doors that separate the Cottage and Lake units. Based on this test strip, he obtained a quote for the replacement of the Cottage unit hallway flooring, with the intention of replacing all of the Ridge building hallway flooring over the span of a few years. He explained that a proposal was submitted to the home's head office for this project, and the funds were not approved. He indicated he would submit another proposal next year.

It was noted that there have been no reported incidents related to the condition of the flooring.

On April 19th, 2016, the MBSM and the Inspector toured the Ridge building to further observe the hallway flooring. It was agreed that the area just inside the Cottage fire door was likely the worst, although the area in close proximity to the Orchard stairway door was also bad. Unless otherwise noted, the size of a noted soft depressed area was approximately the size of a softball. The following was observed: floor weld was starting to separate at the Orchard fire door (approximately one and a half inches); depressed area around #201/#203/med room was in fact the full length of a seam (four ft.) and indicative of total subsurface failure; depressed area in front of the Orchard nurses station, west facing side; very soft depressed area, just past the nurses station, at intersection of the North/South weld; soft depressed area, between #285 and #283, in front of the Purell dispenser and PCC terminal; soft depressed area, in front of the Lake dining room, centre of doorway, approximately five and a half ft. out; floor seam weld failure at #224; further seam weld failure in front of #233 that had not been covered with the Tuck tape; soft depressed area, outside of #216, with several tears in the linoleum. The MBSM and Inspector agreed that it was impossible to fully quantify the issue, as it was dependent on where one stepped, and that this observation process could go on for hours. It was agreed that the examples described above were representative of the

issue. [s. 15. (2) (c)]

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 the Ridge building hallway flooring is maintained in a safe condition and in a good state of repair. The plan must contain measures and strategies to ensure resident safety in light of the degradation of the flooring subsurface in some areas. The plan is to explore options and strategies for flooring repair and replacement as may be necessary. The plan is, to be implemented voluntarily.

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

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

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

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,
(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).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 90 (2) (a) in that the licensee has failed to ensure that procedures are implemented to ensure that the home's generator is maintained at a level that meets manufacturer specifications.

On April 15th, 2016, the Inspector asked the Maintenance and Building Services Manager (MBSM) to discuss the maintenance program for the home's generator. The MBSM explained that a generator maintenance company, Gal Power Systems Ottawa Ltd (Gal Power), conducts a semi-annual and an annual inspection of the generator, and responds to service calls, as applicable. Each inspection includes a general inspection, and the annual inspection includes a semi-annual inspection as well. The MBSM provided the Inspector with generator service documentation from Gal Power for the years 2014 and 2015. The MBSM explained that the home does not conduct additional preventative maintenance for the generator. The MBSM indicated that he did not have the manufacturer specifications for the generator. The MBSM explained that both building are connected to the generator, however in the Ridge building, there is a manual switch. The MBSM indicated that since he started working at the home, July 2014, he estimated that they have flipped the switch eight times, when training registered staff on its use. The MBSM also indicated that every few months, he observes the control panel on the generator, to ensure that readings are where they should be.

On April 18th, 2016, the MBSM provided the Inspector with the licensee's policy, #V-C-20.10 (current revision date of January 2015), related to generator maintenance. The policy directed, in part, that "the generator will be included in the preventative maintenance program for each home and will be tested at a minimum monthly and to all applicable Codes and Laws (Ex. TSSA)".

On April 19th, 2016, the MBSM indicated he had been unable to obtain manufacturer specifications for the generator. The MBSM provided the Inspector with an email from a representative of Gal Power that read, in part, "As per our conversation the manufactures will very in what they require with regards to maintenance and such wording in there specs is not always clear nor written, as they say, in stone. It is our recommendation that along with the bi-yearly visits, monthly transfers be done to properly test the workings on the transfer switch and the generator itself."

On April 19th, 2016, the MBSM provided the Inspector with a copy of the "Generator Test Log Sheet" that he had found in a binder in his office. The log sheet outlined what he believed to be monthly testing requirements (hour meter, battery level, battery charger, coolant level, block heater, oil level, fuel level, voltage, amps, oil press, engine temp, freq.). The MBSM indicated that monthly testing of the generator would be implemented.

Related to the documented service visits for the generator in 2015, there was a service call visit on April 21, 2015; an annual preventive maintenance visit on June 4th, 2015;

and a semi-annual preventive maintenance visit on December 15, 2015. The MBSM explained that in relation to the service call, the reason for the visit was that there had been a power outage in April 2015 and the generator had come on only after three tries. The technician's notes for the service call read, in part, "unit took extra cranking to start. Checked lift pump and pick up tube. Suspect unit sitting for long period, leaked back over time and had to reprime itself". [s. 90. (2) (a)]

2. The licensee has failed to ensure that procedures are developed and implemented to ensure that heating, ventilation and air conditioning (HVAC) systems are cleaned and in a good state of repair and inspected at least every six months by a certified individual.

This finding of non-compliance is specific to the Ridge building.

On April 11th, 2016, in the Ridge building, the Inspector observed that the exhaust system in the following resident washrooms and bathing rooms was not functional: Lake shower room (between bedrooms #234 and #236), #234, #253, #257, #255, #232, #247, Cottage tub and shower room, #226, #222, #218, #216, #225, #223, #216, #281, #279, #277, #261, #236, #238, Cottage tub room. In order to verify if the exhaust was functional, the Inspector held up one square of a single ply of toilet paper to the exhaust vent to determine if there was suction.

On April 13th, 2016, the Inspector discussed the malfunctioning exhaust in the Ridge building with the Administrator and the Maintenance and Building Services Manager (MBSM). The MBSM indicated that he had been made aware, about a month before, that one of the exhaust units for the Ridge building was not functional. The MBSM explained that there were two exhaust units in the Ridge building attic, and that it had been determined that these two units were not a part of the HVAC inspection and maintenance program, as delivered by Coral Engineering Ltd (Coral). The MBSM indicated that he had not been previously aware of these two attic exhaust units.

On April 14th, 2016, a Coral HVAC technician was on site and he confirmed to the Inspector that the malfunctioning exhaust unit had been repaired and the other unit had been observed to be functional.

On April 15th, 2016, the MBSM provided the Inspector with an email from a Coral representative, from April 14th, 2016, confirming that the two exhaust units serviced by the HVAC technician had been added to the equipment list of the HVAC inspection and maintenance agreement.

On April 18th, 2016, the Inspector conducted another round of exhaust system verification in the Ridge building. It was noted that the exhaust system in the Cottage tub and shower room was not functional, and this was reported to the MBSM towards the end of the inspection day. The exhaust in all observed resident bedroom washrooms was functional.

On April 19th, 2016, at 0900 hours, the MBSM provided the Inspector with a copy of a new preventive maintenance agreement with Coral, as agreed to by the Administrator on April 18th, 2016. The MBSM indicated that the two attic units would also be added to the home's daily maintenance check list. Two exhaust systems for the Ridge building were included in the new Schedule B equipment list from Coral and it was indicated they would be inspected four times a year. It was noted by the Inspector and the MBSM that the attic location of these units had not been specified.

On April 19th, 2016, at approximately 1000 hours, the home's maintenance workers confirmed that there was no exhaust in the Cottage tub and shower room, the Cottage tub room, and in the Cottage dining room. It was confirmed that the exhaust for these locations was provided by two roof top units. It was confirmed that in addition to the previously noted attic exhaust units, these two roof top units had not been included in the HVAC inspection and maintenance program, as delivered by Coral. The Coral HVAC technician was called in for immediate service. He observed that the units were in very poor repair and determined that the motors were burnt out. He indicated that he had not been previously aware of the existence of these two roof top units. The MBSM also indicated that he had not been previously aware of these two roof top exhaust units.

On April 20th, 2016, following completion of the on-site inspection, the MBSM emailed the Inspector a work order completed by the Coral HVAC technician on that day, related to the two roof top exhaust units. The technician's notes confirmed that the two roof top exhaust fan units had been remediated and the motors had been replaced. His notes confirmed that the units were now functional. The MBSM stated in his email that the two roof top units would be added to the home's daily maintenance check list.

On April 25th, 2016, following completion of the on-site inspection, a Coral representative provided email confirmation to the Inspector that all four recently discovered exhaust systems in the Ridge building were now included in the new preventive maintenance agreement. An updated equipment list was included, which indicated the units would be inspected four times a year. While the equipment list specified the building in which the

four exhaust systems were located, it did not specify the actual location of the units (i.e attic vs. roof) [s. 90. (2) (c)]

3. The licensee has failed to comply with O. Reg. 79/10, s. 90 (2) (g) in that the licensee has failed to ensure that procedures are developed and implemented to ensure that the temperature of the hot water serving all hand basins used by residents does not exceed 49 degrees Celsius (C).

This finding of non-compliance is specific to the Ridge building.

On April 18th, 2016, the Maintenance and Building Services Manager (MBSM) provided the Inspector with the March 2016 Trillium Ridge Domestic Hot Water Daily Temperature Checklist. Upon review of the completed checklist, it was noted that there were four evening shifts on which the hot water temperature was recorded, in a resident bedroom, in excess of 49 C (March 3rd, #206, 50.1C; March 14th, #228, 49.5C; March 19th, #238, 49.3; March 26th, #259, 49.1C). It was noted that there were nine night shifts on which the hot water temperature was recorded, in a common area that is accessible to residents, in excess of 49 C (ranging from 49.1 C – 56.4 C).

The MBSM indicated to the Inspector that it appeared that the hot water boiler may be set to meet the hot water demands of the day shift, and may be too high for lower demand periods such as the evening and night shift. The MBSM indicated that the boiler had never been adjusted in response to a reported elevated water temperature.

On the evening of April 18th, 2016, between 1735 hours and 1824 hours, the Inspector monitored hot water temperatures in randomly selected bedrooms throughout the Ridge building. Temperatures were found to be in the range of 46.1C – 48.2 C at the time of observation.

On April 19th, beginning at 1047 hours, the Inspector and the MBSM observed that the boiler set point was 140 degrees Fahrenheit (F) and the tank temperature fluctuated between 135 F (57.2 C) and 140 F (60 C). The MBSM explained this fluctuation was in response to the demand at the time. The MBSM highlighted that temperature is lost as the water circulates throughout the building.

During a debriefing discussion, on April 19th, 2016, the MBSM and the Administrator discussed the need to validate the hot water temperature monitoring process that is in place, prior to considering adjustments to the hot water boiler. It was noted that the hot

water temperatures recorded by nursing staff for April 2016 did not include any temperatures above 49 C. Past hot water monitoring records for the Ridge building were not available for review as the records had not been retained. [s. 90. (2) (g)]

4. The licensee has failed to comply with O. Reg. 79/10, s. 90 (2) (h) in that the licensee has failed to ensure that procedures are implemented to ensure that immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius.

This finding of non-compliance is specific to the Ridge building.

As provided to the Inspector by the home's Administrator on April 19th, 2016, the licensee has developed a policy and procedure related to water temperature monitoring, #VII-H-10.70, titled "Water Temperature Monitoring", current revision date of July 2015. The policy indicates, in part, that the RN/RPNs will monitor hot water temperatures in random home areas on each shift, record the water temperatures, and report all temperatures below 40 C and above 49 C to Maintenance Personnel for adjustment and appropriate intervention and document all reports and follow up in the Comments section of the monitoring form. The RN/RPN are directed that if Maintenance Personnel are not available, to contact the Environmental Services Manager (ESM), the Director of Care (DOC), or the ED/Administrator, in that order. The policy directs that the DOC or ESM will implement corrective actions, which may include calling a contracted service provider if home staff are unable to fix the problems, when the water temperature is below 40 C or exceeds 49C.

On April 18th, 2016, the Maintenance and Building Services Manager (MBSM) provided the Inspector with the March 2016 Trillium Ridge Domestic Hot Water Daily Temperature Checklist. Upon review of the completed checklist, it was noted that there were four evening shifts on which the hot water temperature was recorded, in a resident bedroom, in excess of 49 C (March 3rd, #206, 50.1C; March 14th, #228, 49.5C; March 19th, #238, 49.3; March 26th, #259, 49.1C). It was noted that there were nine night shifts on which the hot water temperature was recorded, in a common area that is accessible to residents, in excess of 49 C (ranging from 49.1 C – 56.4 C).

There was no indication of follow up to any of the elevated water temperatures within the comments section of the checklist. Related to the April 2016 checklist, there was one instance of a water temperature that was below 40 C (April 4th, 2016, room #209, 39.1C), and a note was made in the comments section reflecting that a maintenance requisition had been completed.

The MBSM indicated to the Inspector that it appeared that the hot water boiler may be set to meet the hot water demands of the day shift, and may be too high for lower demand period such as the evening and night shift. The MBSM indicated that he did not want calls about slightly elevated water temperatures in the night. He indicated that staff should fill out a maintenance requisition form, to ensure follow up the next day. He indicated that he had no recollection of having ever received a call or a maintenance requisition from staff in the Ridge building about elevated water temperatures. He indicated that the boiler had never been adjusted in response to a reported elevated water temperature.

On April 18th, 2016, at 1524 hours, in the Ridge building, the Inspector spoke with a Registered Nurse (RN), #S100, about actions taken in response to an elevated water temperature. She indicated that she would advise nursing staff of the issue and inform maintenance, if they were in the building. It was clarified that there are maintenance staff present until 5pm. She indicated that for the remainder of the evening shift, and night shift, she would likely send an email to the MBSM, as she did not believe anyone would come in for an elevated water temperature, unless it was excessive. When asked to qualify what "excessive" would be, she said she thought that 55 C would be considered excessive, given they are looking at a maximum of 49 C. The Inspector and the RN noted that at the back of the water temperature checklist, it directed that if the water temperature was in excess of 49 C, the maintenance department should be contacted immediately, and an incident report form should be completed. She qualified that an incident report form would be more likely if there were a few readings in a row above 49C. She explained that she has filled out such a form in the past, only when the temperature was really high.

During a debriefing discussion, on April 19th, 2016, the MBSM and the Administrator discussed the need to validate the hot water temperature monitoring process that is in place, prior to considering adjustments to the hot water boiler. It was noted that the hot water temperatures recorded by nursing staff for April 2016 did not include any temperatures above 49 C. Past hot water monitoring records for the Ridge building were not available for review as the records had not been retained. [s. 90. (2) (h)]

5. The licensee has failed to comply with O. Reg. 79/10, s. 90 (2) (k) in that the licensee has failed to ensure that procedures are implemented to ensure that the water temperature is monitored once per shift in random locations where residents have access to hot water.

This finding of non-compliance applies to both the Court and Ridge buildings.

As provided to the Inspector by the home's Administrator on April 19th, 2016, the licensee has developed a policy and procedure related to water temperature monitoring, #VII-H-10.70, titled "Water Temperature Monitoring", current revision date of July 2015. The policy indicates, in part, that the RN/RPNs will monitor hot water temperatures in random home areas on each shift, and will record the water temperatures on the Water Temperature Monitoring Record attached to the policy (VII-H-10.70(a)) or to a home specific monitoring record.

On April 15th and 19th, 2016, the Inspector reviewed the "Resident Care Area Water Temperatures" recording form in use for the Court building, as located on the wall in the nurses' station on the Heritage House unit. As of April 19th, 2016, with the exception of two days (14th and 18th), it was noted that temperatures had not been monitored once per shift for the month to date. There were four days on which there was no hot water temperatures recorded (6th, 7th, 16th and 17th). There were two days on which there was one of three required hot water temperatures recorded (3rd, 11th). There were nine days on which there was two of three required hot water temperatures recorded (1st,2nd,4th,5th,8th,9th,10th,12th,13th). In total, 28 of 54 required hot water temperatures were not recorded.

It was also noted that the hot water temperatures were not recorded in random home areas in the Court building. All hot water temperatures were recorded in the Heritage House unit. It was also noted that the hot water temperatures were not recorded in random locations within the Heritage House unit. Of the 21 bedroom hot water temperatures recorded, 17 were taken in bedrooms #205 or #206. As well, not all hot water temperatures were taken in locations where residents have access to hot water. Two temperatures were taken in the unit medication room, and four were taken in the unit dining room, which is locked after 2000hrs.

On April 18th, 2016, the Inspector reviewed the "Domestic Hot Water Daily Temperature Checklist" recording form in use for the Ridge building, as located on the wall in the nurses' station on the Lake House unit. This recording form differed from that in use in the Court building, as the testing locations were predetermined. It was noted that hot water temperatures had not been monitored once per shift, on any day, for the month to date. There were three days on which there was no hot water temperatures recorded (1st, 2nd, 3rd). There were six days on which there was one of three required hot water

temperatures recorded (4th, 6th, 8th, 11th, 12th, 14th). There were eight days on which there was two of three required hot water temperatures recorded (5th, 7th,9th, 10th, 13th, 15th – 17th). In total, 23 of 52 required hot water temperatures were not recorded.

It was noted that the pre-determined monitoring locations for the night shift were not always locations where residents had access to hot water. Residents would not have access to hot water in the Sunshine dining room, which is kept locked at night, nor would they have access to hot water in the tub and shower rooms, which are locked at all times.

The Inspector requested additional hot water monitoring records for the Court and Ridge buildings. The Maintenance and Building Services Manager (MBSM) located the March 2016 recording sheet for the Ridge building, and informed that other past records had not been retained. [s. 90. (2) (k)]

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 the home's generator is kept in good repair and maintained at a level that meets manufacturer specifications, at a minimum; to ensure that all components of the heating, ventilation and air conditioning (HVAC) systems, for both buildings, are cleaned, in a good state of repair and inspected at least every six months by a certified individual; to ensure to ensure that the temperature of the water serving all bathtubs and shower and hand basins used by residents in the Ridge building does not exceed 49 degrees Celsius (C); to ensure that immediate action is taken to reduce water temperatures in the Ridge building in the event that it exceeds 49 C; to ensure that the water temperature in both buildings is monitored once per shift in random locations where residents have access to hot water.

The plan is to include a strategy to obtain and implement the manufacturer specifications related to maintenance of the generator. The plan is to include measures to ensure the full implementation of the licensee's policy related to generator maintenance, #V-C-20.10

The plan is to include a process whereby all components of the HVAC systems for both buildings are inventoried and included in the HVAC inspection and

maintenance agreement. The plan is to include a process whereby the precise location (ie. Ridge attic, Ridge roof) of all inventoried HVAC system components is captured on the equipment list associated with the HVAC inspection and maintenance agreement.

The plan is to include a process whereby the licensee's policy related to water temperature monitoring (#VII-H-10.70) is reviewed, by all of the home's staff involved in it's implementation, and revised if needed to reflect actual practice. The plan is to include a strategy that will ensure the provision of water below 49 C, at all times in the Ridge building, despite varying demands on the system. The plan is to include a strategy that provides for follow up review of water temperature monitoring checklists, for both buildings, by management staff. The plan is to include a strategy that provides for the retention of water temperature monitoring checklists.

The plan is, to be implemented voluntarily.

Issued on this 28th day of April, 2016

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

Original report signed by the inspector.