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 East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: September 6, 2024
Original Report Issue Date: August 16, 2024
Inspection Number: 2024-1356-0002 (A1)
Inspection Type: Complaint Critical Incident
Licensee: Axium Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axium Extendicare LTC II GP Inc.
Long Term Care Home and City: Winbourne Park, Ajax

AMENDED INSPECTION SUMMARY

This report has been amended to:
- Rescind Compliance Order #005 pursuant to O. Reg. 246/22, s. 24 (3).
-COs #001 and #004 compliance due date changed to October 15, 2024.

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- Rescind Compliance Order #005 pursuant to O. Reg. 246/22, s. 24 (3).
-COs #001 and #004 compliance due date changed to October 15, 2024.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 8-12, 16-19, 2024

The following intake(s) were inspected:
- Seven intakes were related to alleged abuse
- One intake was related to a fall with fracture
- One intake was related to resident to resident abuse
- One intake was related to an infectious disease outbreak
- One intake was related to improper care of a resident

- One complaint was related to palliative care, skin and wound care, and dining services

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC # 001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (c)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure injuries, skin tears or wounds and promote healing;

The licensee has failed to ensure that positioning aides were readily available to staff caring for a resident.

Rationale and Summary

A complaint was received by the Ministry of Long Term Care (MLTC) related to multiple areas of a resident's care including the inappropriate use of repositioning

devices. The complainant alleged that staff used an inappropriate repositioning device to reposition the resident in bed.

The resident's plan of care stated that they were at risk for impaired skin integrity and required assistance with repositioning.

The Safe Ambulation Lift Transfer Skills Checklist indicated that a specific repositioning device was required to be used to reposition residents in bed.

The Registered Nurse (RN) informed the inspector that they were approached about staff using an inappropriate repositioning device on the resident. The RN confirmed that staff used an inappropriate repositioning device. The RN and the Administrator acknowledged staff used the incorrect repositioning device.

Failure to ensure that the appropriate repositioning device was available placed the resident at risk of skin break down.

Sources: The resident's plan of care, The Safe Ambulation Lift Transfer Skills Checklist, Interviews with the RN, and the Administrator.

WRITTEN NOTIFICATION: POLICY TO PROMOTE ZERO TOLERANCE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with.

The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director related to staff to resident abuse. According to the CIR, a Personal Support Worker (PSW) had a negative interaction with a resident, causing emotional distress to the resident.

The home's investigation notes indicated that the resident reported the incident to a PSW. The PSW confirmed that the resident was emotionally distressed about the interaction and asked for the allegation to be reported to the Director of Care (DOC).

According to the home's policy "Resident Non-Abuse Program", staff were required to immediately report all allegations of resident abuse to the staff in charge.

The PSW confirmed that they did not immediately report it to anyone as the DOC was not available and decided to wait the next day until the DOC was in the home. The PSW acknowledged they were aware that they were required to immediately report the allegation to the staff in charge.

Failure to follow the home's policy to promote zero tolerance of abuse and neglect of residents delayed the home's investigation putting the resident at risk of further abuse.

Sources: Resident Non-Abuse Program policy #ADMIN-O10.01 Modified January 30, 2024, the home's investigation notes, and interview with the PSW.

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that when a resident demonstrated responsive behaviours, that strategies were implemented to respond to their behaviours.

Rationale and Summary
A CIR was submitted to the Director regarding an allegation of abuse of a resident. According to the CIR, the resident alleged that two staff provided rough care.

The home's investigation notes indicated that on the day of the incident, a PSW, and Personal Care Assistant (PCA) provided care to a resident. During this interaction, the resident displayed responsive behaviours.

The resident's plan of care indicated that if the resident were to display responsive behaviours, staff were required to implement strategies to manage those behaviours.

The PCA confirmed that the interventions in the care plan were not utilized. The Regional Director confirmed that the staff should have followed the interventions specified in the care plan.

Failure to implement the strategies designed to manage the resident's responsive behaviours caused emotional distress to the resident.

Sources: The resident's plan of care, interviews with the PCA and the Regional Director.

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The licensee has failed to ensure that staff used proper techniques to assist a resident with eating.

Rationale and Summary
A complaint was sent to the MLTC regarding inappropriate feeding technique when feeding a resident. A CIR was also submitted by the home related to this concern.

The resident's records indicated that the resident suffered a decline in health due to their medical diagnosis which resulted in the resident's inability to self-feed.

Furthermore, the plan of care indicated that due to nutritional risk, the resident required assistance with oral care. The complainant alleged that the resident was fed in an unsafe manner.

The home's training module on meal and snack assistance provided specifics on how to feed residents safely. The Registered Practical Nurse (RPN) and the administrator confirmed that the required technique was not followed when feeding the resident.

Failure to ensure that the resident was fed using safe techniques placed the resident at nutritional risk.

Sources: The resident's health records, Training module "Meal and Snack Assistance Module 3: Preparation and Assistance", interviews with the RPN and the Administrator.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #005 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).

1) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Rationale and Summary
Specifically, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes last revised September 2023, s. 11.6 stated that the licensee was to provide individuals with information to monitor their health at home and to post signage at entrances and throughout the home that lists the signs and symptoms of infectious diseases.

A CIR was received by the Director for an infectious disease outbreak. Upon entrance to the home, the Inspector observed a list of signs and symptoms of infectious diseases but not throughout the home. The IPAC Lead confirmed the signage is not throughout the home as they wanted to maintain the home as a resident space.

Observation of the passive screening process did not provide information for staff and visitors to monitor their health at home. The IPAC Lead confirmed they did not provide information for people to screen at home.

According to Extendicare Pandemic Playbook for passive screening all team members, students and volunteers who fail the screening will not enter the building.

Failure to provide information to monitor people's health and to post signage throughout the home that lists signs and symptoms put residents at risk for infection.

Sources: Observations, interview with staff and Extendicare Pandemic Playbook.

2) The licensee has failed to implement routine precaution measure by not cleaning resident room floors daily.

Rationale and Summary
In Accordance with the IPAC Standard for Long-Term Care Homes issued by the director, revised September 2022, section 5.3 (h) the licensee shall ensure that the policies and procedures for the IPAC program include policies and procedures for the implementation of Routine Practices and Additional Precautions including but not limited to cleaning and disinfecting.

A CIR was received by the Director for an outbreak. The inspector observed a Housekeeper wash some resident room floors and not others. Interview with the Housekeeper confirmed that not all resident room floors were cleaned daily and only floors that were sticky were cleaned daily.

The Environmental Services Manager (ESM) confirmed resident room floors were to be cleaned daily as a routine practice. The Resident Room Daily Cleaning and Disinfecting Policy confirmed resident room floors were to be cleaned daily.

Failure to follow the homes cleaning and disinfecting policy put the residents at risk for infection.

Sources: observations, interview with staff and policy ES-C-10-05 Resident Room Daily Cleaning and Disinfecting.

3) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Rationale and Summary
Specifically, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes last revised September 2023, s. 10.1 states that the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents that shall be easily accessible at both point-of care and in other resident and common areas.
A CIR was received by the Director for an infectious diseases outbreak. The Inspector observed a PSW exit a resident room without completing the four

moments of hand hygiene prior to leaving the room due to not having any hand sanitizer immediately available.

There was no Alcohol Hand Based Rub (ABHR) in the resident den and dining room extension on both the first and second floors.

After having resident interaction, Four PSWs were observed leaving resident rooms to access alcohol-based rub located outside the resident room. The IPAC Lead confirmed that adding hand sanitizer dispensers in the room prior to exiting would not be necessary. The Administrator confirmed the four moments of hand hygiene and that it could not be achieved with current resident room set up.

As per Extendicare's Pandemic Playbook, each staff was required to practice the four moments of hand hygiene.

Failure to provide ABHR at easily accessible location such as resident room exits, increases the risk of infectious agent transmission.

Sources: observations, interview with staff Extendicare Pandemic Playbook.

4) The licensee has failed to provide a hand hygiene program which includes at a minimum access to hand hygiene agents at the point-of-care.

Rationale and Summary
In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, revised September 2023, section 10.3 states that hand washing provisioned with appropriate supplies must also be accessible in common areas and work areas where hand washing is required.

A CIR was received by the Director for an infectious diseases outbreak. Inspector observed four PSWs leave resident rooms to access the hand sanitizer dispenser. Multiple resident rooms throughout the home did not have hand sanitizer dispensers at the point to care.

The IPAC Lead confirmed that adding hand sanitizer dispensers in the room prior to exiting would not be necessary and suggested that staff use the point of care ABHR or exit the room to access the dispenser in the hallway. The Administrator confirmed the four moments of hand hygiene and that it could not be achieved with current resident room set up.

Public Health Ontario (PHO), Best Practice for hand hygiene defined the point of care as the place where three elements occur together: the client/patient/resident, the health care provider and care or treatment involving client/patient/resident contact. The concept was used to locate hand hygiene products which were easily accessible to staff by being as close as possible, i.e., within arm's reach, to where client/patient/resident contact is taking place.

Failure to provide hand sanitizer at the point to care puts residents at risk for infection.

Sources: observations, interview with staff and review of IPAC Standard September 2023 and PHO Best Practice for Hand Hygiene dated December 19, 2023.

5) The licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program by utilizing best practice guidelines with the placement of Personal Protective Equipment (PPE) receptacles.

In accordance with the IPAC Standard for Long-Term Care Homes issued by the director, revised September 2023, section 9.1 (f) states Additional PPE requirements including appropriate selection application, removal, and disposal.

Rationale and Summary
A CIR was received by the Director for an infectious diseases outbreak. The Inspectors observed a PPE receptacle located outside an additional precaution room. The IPAC Lead confirmed they were not aware that PPE receptacles were to be located inside the resident room. An RPN confirmed that PPE garbage

receptacles had always been housed outside the resident room. As per the Provincial Infectious Disease Advisory committee (PIDAC), when the interaction for which PPE was used has ended, PPE should be removed immediately and disposed of.

Failure to implement best practice guideline for the doffing of PPE, put residents at risk for infection.

Sources: Observation, interview with staff and PIDAC Best Practices for PPE (2012).

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

The licensee has failed to ensure that a documented record of the investigations, the outcomes of the investigations and the actions taken as a result of the outcomes of the investigations is kept in the home.

Rationale and Summary
A verbal complaint was received by the former DOC related to alleged emotional abuse of a resident.

A review of the employee record revealed no documented record of the investigations, and the actions taken as a result of the outcomes of the investigations.

The Former DOC acknowledged not having a documented record of the investigations, and the actions taken as a result of the outcomes of the investigations.

The former DOC indicated the final resolution of the investigations was focused more on corrective education, and a learning opportunity for the staff involved. The former DOC indicated training was provided to staff. However, there is no documentation in Point Click Care (PCC) or in the staff file indicating the completion of any of these training. Furthermore, The PSW indicated not receiving any training.

Failure of the home to have a documented record of the investigations and the actions taken as a result of the outcomes of the investigations places the resident at risk of future abuse and prevented the home of potentially identifying trends of abuse in the home.

Sources: Progress notes, employee file, and Interviews with the , former DOC, and the Administrator.

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (3)
Dealing with complaints
s. 108 (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly;
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and
(c) a written record is kept of each review and of the improvements made in response.

The licensee has failed to ensure that a documented record of the investigations, the outcomes of the investigations and the actions taken as a result of the outcomes of the investigations is kept in the home.

Rationale and Summary
A verbal complaint was received by the former DOC alleging emotional abuse of a resident.

A review of the home's records to address the allegations, revealed no information about the investigations, the outcomes of the investigations and the actions taken as a result of the investigations.

Interviews with former DOC and the Administrator indicated that there was no documented record of the investigations, the outcomes of the investigations and the actions taken as a result of the investigations.

Failure to have a documented record of the investigations, and the actions taken as a result of the outcomes of the investigations, prevented the home of potentially identifying trends of abuse, analyzing trends, and thus, prevents the home in making improvements based on analyzed trends.

Sources: Progress notes, employee file, and Interviews with the former DOC, and the Administrator.

COMPLIANCE ORDER CO #001 Cooling requirements

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 23 (4)
Cooling requirements
s. 23 (4) The heat related illness prevention and management plan for the home shall be implemented by the licensee every year during the period from May 15 to September 15 and it shall also be implemented,
(a) any day on which the outside temperature forecasted by Environment and

Climate Change Canada for the area in which the home is located is 26 degrees Celsius or above at any point during the day; and
(b) anytime the temperature in an area in the home measured by the licensee in accordance with subsections 24 (2), (3) and (4) reaches 26 degrees Celsius or above, for the remainder of the day and the following day. O. Reg. 246/22, s. 23 (4).

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

Specifically, the licensee shall, at a minimum:
1) Implement the homes heat related illness prevention and management plan for the home that meets the needs of the residents in accordance with evidence-based practice during the hot months.

a) The ESM with the leadership team is to develop and implement a process to measure external and internal air temperatures (as per legislation) and when to implement the heat related illness plan.
b) The Leadership team will provide in-person education to all staff about the homes heat related illness prevention and management plan including but not limited to the location of designated cooling stations and how to take appropriate ambient air temperatures.
c) Keep a documented record of the education provided, who received the education, the name of the leadership team member who provided the education, the education completion date, and the contents of the education and training materials.
d) Make this record available to the inspector immediately upon request.

Grounds
The licensee has failed to implement the heat related illness prevention and management plan for the home when temperatures outside and inside the home measured above 26 degrees.

Rationale and Summary

This intake was initiated on an on-site inspection due to observed increased air temperature in resident home areas. On specified date, Environment Canada issued a special weather statement for hot temperatures of 28 degrees Celsius and advised people to be cautious for heat related illnesses.

The Inspector did not observe any signage to communicate the extreme heat weather conditions or signs and symptoms of heat related illnesses at the entrance or throughout the home.

On two Resident Home Areas (RHA) the Inspector observed a thermostat readings of 26.1 degrees Celsius. The Inspector did not observe residents being moved to another cooling area.

The Administrator confirmed that specific rooms were designated cooling stations. However, one of the cooling stations was above 26.1 degrees Celsius, and the central core of the home could not accommodate more than 40 residents. Three PSWs could not identify where the cooling stations were in the home for when the temperature raised above 26 degrees Celsius.

Failure to implement the homes heat related illness prevention plan put residents at risk for heat related illnesses.

Sources: Observation, interview with staff and the homes interdisciplinary heat response plan template.

This order must be complied with by October 15, 2024

COMPLIANCE ORDER CO #002 COOLING REQUIREMENTS

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 23 (1)

Cooling requirements

s. 23 (1) Every licensee of a long-term care home shall ensure that a written heat

related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices. O. Reg. 246/22, s. 23 (1).

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

Specifically, the licensee shall, at a minimum:

1) The Administrator, Director of Care and Environmental Service Manager is to develop and implement a heat related illness prevention and management plan for the home that meets the needs of the residents in accordance with evidence-based practice.

a) The Leadership team will Provide in-person education to all staff about the homes heat related illness prevention and management plan.
b) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.
c) Make this record available to the inspector immediately upon request.
d) The home is to demonstrate the inclusion of the heat related illness prevention and management plan into the homes annual training.

Grounds

The licensee has failed to ensure that a written heat related illness prevention and management plan for the home that meets the needs of the residents was developed in accordance with evidence-based practice.

Rationale and Summary

This intake was initiated on an on-site inspection due to observed increased air temperature in resident home areas. On a specified date, Environment Canada issued a special weather statement for hot temperatures of 28 degrees Celsius and advised people to be cautious for heal related illnesses.

The homes interdisciplinary heat response plan template was provided by the Administrator which lacked specific risk factors and symptoms that could lead to heat related illness. The Administrator confirmed the home was in the process of updating their heat related illness policy.

Failure to implement a heat related illness prevention plan put residents at risk for heat related illnesses.

Sources: The interdisciplinary heat response plan template and interview with staff.

This order must be complied with by October 15, 2024

COMPLIANCE ORDER CO #003 Cooling requirements

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 23 (2)
Cooling requirements
s. 23 (2) The heat related illness prevention and management plan must, at a minimum,
(a) identify specific risk factors that may lead to heat related illness and require staff to regularly monitor whether residents are exposed to such risk factors and take appropriate actions in response;
(b) identify symptoms of heat related illness and require staff to regularly monitor whether residents exhibit those symptoms and take appropriate actions in response;
(c) identify specific interventions and strategies that staff are to implement to prevent or mitigate the identified risk factors that may lead to heat related illness and to prevent or mitigate the identified symptoms of such an illness in residents;
(d) include the use of air conditioning, cooling equipment and other resources, as necessary, to protect residents from heat related illness; and
(e) include a protocol for appropriately communicating the heat related illness prevention and management plan to residents, staff, volunteers, substitute decision-

makers, visitors, the Residents' Council of the home, the Family Council of the home, if any, and others where appropriate. O. Reg. 246/22, s. 23 (2); O. Reg. 66/23, s. 3 (1).

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

Specifically, the licensee shall, at a minimum:

1) Establish and implement a heat management team to manage temperatures that meets compliance with legislation.

a) ED and ESM to establish and implement a heat management team.
b) The home is to provide in-person training to the heat management team regarding but not limited to their role on the heat management team.
c) The ESM or management designate is to develop and implement a protocol to communicate how to manage hot weather illnesses.
d) The ESM or management designate is to develop and implement a process for monitoring temperatures and what is to be accomplished if temperatures are found above 26 degrees Celsius or below 22 degrees Celsius.
e) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.
f) Make this record available to the inspector immediately upon request.

Grounds

The licensee has failed to ensure the air conditioning is operational and in good working order.

Rationale and Summary

This intake was initiated on an on-site inspection due to observed increased air temperature in resident home areas. On a specified date, The Weather Network for

Ajax confirmed a special weather statement for increased temperatures. Interviews with two residents confirmed they found the dining room hot at times and travel throughout the home to feel relief.

A walk through the home with the Environmental Services Manager confirmed air temperatures with an infrared thermometer which produced temperatures of 26.1 degrees Celsius on a specific part of the building.

A RHA's area air temperature measured at 26.1 degrees Celsius. The ESM confirmed the air temperature for the RHA was changed to heat.

The Inspector observed a broken protective cover over the thermostat unit. Another RHA dining area was measuring at 26.1 degrees Celsius. The Administrator confirmed the AC unit which supplies cold air to the specified area of the building was only working at half capacity.

Failure to implement a heat related illness prevention and management plan put residents at risk for heat related illnesses.

Sources: Observations, interview with staff and the homes temperature policy.

This order must be complied with by October 15, 2024

COMPLIANCE ORDER CO #004 Air temperature

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 24 (2).
Air temperature
s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing.

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

1) Procure and implement an appropriate air measuring device to measure the homes air temperatures.

a) The ESM and/or Leadership team is to educate staff taking temperatures on how to use the air measuring device and the temperature log form for documentation.
b) The ESM is to review the temperatures logs daily to ensure accuracy and provide corrective actions if non-compliance is identified. Make this record available to the inspector upon request.
c) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.
d) Make this record available to the inspector immediately upon request.

Grounds
The license has failed to ensure that temperatures in the home are measured and documented in writing.

Rationale and Summary
This intake was initiated on an on-site inspection due to observed increased air temperature in resident home areas. On a tour with the ESM, temperatures were taken using an infrared thermometer which did not give true readings as it measured the temperatures of objects and not ambient air. Temperatures produced ranged between 23.7-26.1 degrees Celsius.

While on site the home purchased hygrometer thermometers to measure ambient air and was provided to every unit in the home. The Inspector went through the home to compare the readings from the new thermometer to those of the one thermometer. Air temperature readings confirmed the infrared thermometer was not reading accurate when compared to the HUMIE report. The ESM and

Administrator have confirmed the home has been using infrared thermometers to measure air temperatures.

According to the manufacturers manual for the homes Infrared (IF) thermometer model number contained an integrated sensor head that detected the material/surface-specific infrared radiation emitted by all objects.
Failure to utilize a thermometer that measured ambient air put residents at risk for heat related illnesses.

Sources: Observations and interviews with staff.

This order must be complied with by October 15, 2024

(A1)
The following order(s) has been rescinded: CO #005

COMPLIANCE ORDER CO #005 Air Temperature

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 24 (3)
Air temperature
s. 24 (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

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

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.