Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under *the Long-Term Care Homes Act, 2007*

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 02, 2021	2021_769646_0011 (A2)	008846-21	Complaint

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

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

Woodbridge Vista Care Community
5400 Steeles Avenue West Woodbridge ON L4L 9S1

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

Amended by IVY LAM (646) - (A2)

Amended 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): June 4, 7 to 11, and 14 to 17, 2021.

The following complaint log was inspected during this inspection:

- Log #008846-21 related to allegations of neglect, and concerns regarding the home's complaints process, response to family council; heating, ventilation and air conditioning (HVAC) system, and heat related illness prevention and management process.

A mandatory heat inspection was also completed during this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Corporate Vice-President of Regional Operations, Resident Assessment Instrument (RAI) Coordinator, Director of Environmental Services (DES), Previous DES, Heavy Duty Supervisor, Maintenance Supervisor, District Manager - Compass, Building Services Partner, Physician, Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurse (RPN), Nursing students, Personal Support Workers (PSW), Acting Manager for COVID response for York Region Public Health, Public Health Inspectors, Family Council President, Complainants, Substitute Decision Makers (SDM), Family Members, and Residents.

During the course of the inspection, the inspectors conducted tours of home areas, observations of staff and resident interactions and the provision of care, reviewed resident health records, relevant home's documents, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Family Council
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Safe and Secure Home

During the course of the original inspection, Non-Compliances were issued.
9 WN(s)
7 VPC(s)
2 CO(s)
1 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	Légende 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was protected from neglect.

As per O. Reg. 79/10, s. 5, the definition of "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The home submitted a Critical Incident System (CIS) report related to a resident being found seated in soiled clothing, with a dirty assistive mobility device, and severely dehydrated. A complaint was additionally forwarded to the Ministry of Long-term Care (MLTC) related to the above concerns.

The resident’s family member stated that they called into the home almost daily to ask the staff about the resident’s fluid and meal intake and general health condition. They were informed that the resident’s intake was good and the home did not indicate any concerns about the resident’s intake. The family member later found the resident unkempt with dried food on their clothes, and the assistive mobility device dirty. The family indicated that they informed the charge nurse of the condition they found the resident in and had previous concerns about the resident’s hygiene and cleanliness prior to this date.

The inspector reviewed images that were taken by the resident’s family member and observed a substance was noted on the resident's shoulder and hair, scaly skin around their mouth, and stains on the resident's sweater, pants and assistive mobility device.

A Registered Practical Nurse (RPN) informed the resident’s family member that they would continue to monitor the resident. Six days later, the resident’s

Substitute Decision Maker (SDM) reported that the resident appeared weaker, in pain and was unable to reposition themselves in their assistive mobility device. A referral was made to physiotherapy, pain monitoring and a urine culture and sensitivity was ordered by the Nurse Practitioner (NP) during the day shift. That same evening, the RPN noted that the resident was sleepier than usual and was gurgling their fluids. The RPN took the resident's vital signs which showed a change in the resident's blood pressure in the afternoon compared to the morning blood pressure. The RPN left a note for the physician to follow up the next day. No other additional assessments were completed related to the resident's lethargy or gurgling of fluids, nor was the on-call physician notified.

The next day, the physician was completing their rounds and observed that the resident was lethargic and slumped in their assistive mobility device. An assessment showed the resident continued to experience a change in their BP from baseline, had dry oral mucosa and was lethargic. The physician determined that the resident was clinically dehydrated, initiated hypodermoclysis and ordered bloodwork. The resident was sent to hospital three days later, as their bloodwork showed elevated levels of sodium and chloride, and low levels of potassium. In the hospital, the resident's blood sugar was abnormally high. The resident had no history of the health condition prior to the hospital admission, but returned to the home with a new diagnosis and new medication.

A week prior to the resident's diagnosis of dehydration, a Personal Support Worker (PSW) indicated they had observed the resident with declined in energy levels, required more assistance and had a decrease in food intake. The PSW indicated that they observed the resident to be in pain and reported this to the nurse. The progress notes on the day they reported did not show that a pain assessment was completed.

The resident's fluid intake documentation showed that the resident had met and sometimes exceeded, their required fluid intake for the time period that they were identified with dehydration. Observations of the resident's meal intake showed that resident had suboptimal intake at most meals, and they had fully consumed their oral nutritional supplement. There was no consistent documentation noted to identify the exact percentage of the meal the resident had consumed.

An RPN student indicated that during a meal service service, the resident had 0.5 servings of fluid. The documentation for that day showed that a total of 1.5 servings was given to the resident at that meal service.

Observations the next day during a meal service showed indicated the resident had consumed one serving of juice, 120 milliliters (mls) of oral nutritional supplement and 20% of another fluid for a total of 2.2 servings. The documentation for the same meal service that day, indicated the resident received 3.7 servings. The staff had not consistently and accurately documented the resident's fluid intake, which increased the risk of inaccurate assessment of fluid intake.

On four separate days, a PSW reported to the registered staff that the resident did not eat their meal. On three other days, the resident's intake was consistently at or below 50%. Registered staff relied on an alerting system in PointClickCare (PCC) to indicate to them when a resident had consumed less than 50% at meals. The progress notes did not show any additional assessments or monitoring was initiated for the resident during the abovementioned period.

The resident's care plan after the resident returned from hospital did not show any changes or revisions to interventions related to their hydration status; their risk for heat related illnesses was not reviewed and was not based on an interdisciplinary assessment.

The Physician and Director of Care (DOC) indicated that there were inconsistencies with the resident's fluid intake. The Physician #120 indicated that to have a resident dehydrated was negligent as staff were required to monitor residents for dehydration.

The DOC indicated that staff were required to complete a full assessment on the resident when they were observed a change in health status, which had occurred twide for the resident during the abovementioned period, which included contacting the on-call physician. Based on the home's investigation, the DOC determined that the resident was neglected when the Registered staff had not completed a full assessment when the resident had a change in health status.

[Sources: Review of Critical Incident System (CIS) report, home's investigation notes, progress notes, care plan, point of care documentation, documentation survey reports; Observations of resident and staff; Interviews with complainant, Physician, DOC, PSW, RPN student, and other relevant staff.] [s. 19. (1)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1.3) 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 O. Reg. 79/10, s. 20 (1.3).
(b) anytime the temperature in an area in the home measured by the licensee in accordance with subsections 21 (2) and (3) reaches 26 degrees Celsius or above, for the remainder of the day and the following day. O. Reg. 79/10, s. 20 (1.3).

s. 20. (3) The licensee shall ensure that every designated cooling area in the home is served by air conditioning which is operated, as necessary, to maintain the temperature in the designated cooling area at a comfortable level for residents during the period and at the times described in subsection (1.3). O. Reg. 79/10, s. 20 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the heat related illness prevention and management plan for the home was implemented by the licensee during the period from May 15 to June 9, 2021; and anytime the temperature in an area in the home measured by the licensee reached 26 degrees Celsius or above, for the remainder of the day and the following day.

As per the home's policy, summertime practice was to be implemented in the home when the relative humidity was less than 50% and the indoor temperature was between 23-26%. The maintenance staff were to record the indoor temperature and humidity percentage on the Air Temperature Log and inform all departments of the heat contingency protocols to be implemented. They were also to ensure at least one separate designated cooling area was available for every 40 residents. Hot weather protocols for nurses and PSWs included monitoring all residents for signs and symptoms of heat related illness, and to ensure water and cold drinks were available and easily accessible.

When the relative humidity in the home was greater than 50% and the indoor temperature was 26.1-32 degrees Celsius (C), or when the relative humidity was

less than 50% and the indoor temperature was 28-34 degrees C, an intervention alert should have been issued. The maintenance team was to continue previous measures and collaborate with the Executive Director (ED) to determine the need to move residents to a common air conditioned/cooling area and ensure all in-room air conditioners were working. The nursing team were to offer increased fluids, ensure if a fan was used in a resident's room, it was not blowing directly on a resident. The residents should have been encouraged to move to an area in the home with air conditioning.

The Air Temperature Log form was updated to remind the staff members who took the temperature recordings to notify the charge nurse, to take action for elevated temperatures recorded, and to escalate heat concerns to the ED. The form was provided to the Director of Environmental Services (DES) on an identified day. The DES provided the form to the maintenance team members four days later, but the form was not used by all maintenance team members until more than one month after.

The maintenance team members were observed to take temperature and humidity measurements in the home using one handheld thermohygrometer. The handheld device was stored in the basement or in the DES' office, and the one handheld device was shared on all home areas. The thermohygrometer was not left in the room environment for the appropriate length of time in accordance with manufacturer's instructions.

On an identified day, the temperature on three floors in the home reached 26 degrees C with humidity of 51%. A Maintenance staff indicated they did not alert the nurse in charge but had submitted the temperature log to their manager. The DES stated they had received the log but the temperature was acceptable in their opinion and the home remained in summertime practice.

The next day, the afternoon temperature and humidity recordings on two floors reached intervention alert with the temperature between 26.4-28.1 degrees C and humidity of 47-54%, with the humidex ranging from 31-32. The nighttime temperature reached intervention alert levels on all units, with room temperatures ranging from 26-29 degrees C, humidity ranging 52-62%, and humidex 30-37. A PSW and an RPN stated the building was hot that day, but there was nowhere to bring the residents to for cooling, as there was no air conditioning in the dining, TV, and activity rooms.

The Maintenance staff and the heavy-duty supervisor who took the temperatures on the second day, indicated they had not communicated about the temperature or humidity levels to the charge nurses, but had submitted the temperature logs to the DES and the ED. The DES indicated they had not communicated an intervention alert to the charge nurses that day, as the heavy-duty supervisor told them they had already communicated the intervention alert to the charge nurse. Registered staff working on day, evening, and night shifts indicated they saw maintenance team members take the temperature, but the staff did not inform them of the temperature and humidity or any level of alert. They further stated there were no shift reports indicating intervention alert in the home.

On the third day, the temperature and humidity recordings on all units reached intervention alert. The Maintenance staff stated they had taken the temperature and humidity measurements. They indicated it was the maintenance staff or the DES' responsibility to inform the nurses of the heat in residents' rooms and to suggest moving residents to another location, but they did not inform the nurses because they did not have time. The RPN stated they continued summertime practice and was not informed by the maintenance staff or any manager of an intervention alert, but would rely on their nursing judgment or the PSWs' request to provide additional interventions.

On the third day, a resident was found in their room with a room temperature of 28 degrees C and humidity of 83%. On the fourth day, the resident was found in their room, with a room temperature of 27 degrees C and humidity of 84%. Two fans were directed at the resident, with one fan facing the entrance, with the stream of air flowing to the resident and directly towards the room entrance. A PSW indicated the resident had a condition which required them to remain in their room, but they had provided an extra fan for the resident. They stated they had not provided the resident with additional fluids beyond their regular fluids, as the resident consumed their fluids well at meals and snack times. They would encourage additional fluids if the resident did not complete their scheduled fluids.

The DES and the District Manager for environmental services indicated cooling fans were provided for the resident, but the communication process of the air temperature heat alert levels between the maintenance and the nursing team was still in development and not properly implemented until July 9, 2021.

Interviews with PSWs, RPNs and the Registered Nurse (RN) between the second

to fourth days, showed the staff members were not aware of the difference between summertime practices and intervention alerts. They were not aware of any additional measures needed during an intervention alert. The nurses did not know how to take indoor temperature and humidity readings, were not aware of where the thermohygrometer was located, or where to find the Air Temperature Log. They were not aware that, according to the policy, they were to measure the indoor air temperature/humidity in the absence of maintenance team members.

The DOC indicated education on the updated policy and heat contingency protocol was provided for 25 registered staff and PSWs on the second day and continued to provide the education to other staff. Nurses were to receive intervention alerts from the maintenance staff based on the temperature and humidity measurements, and additional interventions would be provided. They further indicated the registered staff and maintenance staff should have escalated the heat concerns to the appropriate managers to identify and relocate residents to cooler areas in the home when the home reached an intervention alert and the designated cooling areas were not cooler than the residents' rooms. They stated that the identified resident should have been brought to a cooler area or the registered staff should have requested an additional cooling unit be provided in the resident's room. The ED indicated the fan should not be aimed directly at the resident, and should not be blowing towards the door entrance, and that this had been corrected. Registered staff should also have been aware of the heat contingency protocol, including the additional steps and communication needed for an intervention alert.

The ED indicated the maintenance team were expected to use the Air Temperature Log form on or after the day it was provided to the DES, and the DES was to ensure the maintenance staff communicate appropriate heat alerts to the nursing staff. The maintenance team or DES should have escalated the concerns to the ED or a manager-on-call when the cooling fans were provided to residents, but the home remained in intervention alert level, to discuss the need to relocate residents to cooler areas in the home until the designated cooling areas were operational.

The home's heat related illness prevention and management plan was not fully implemented during the period beginning May 15, 2021. There was a potential risk of heat-related illness to the residents during this period.

[Sources: Home's Prevention & Management of Heat Related illness policy, Heat

Contingency Protocol, Hot Weather Cooling Areas policy attachment, A/C Units Audit Forms, Air Temperature Log Forms; Observations of residents' rooms, observations of cooling areas, resident and staff observations, thermohygrometer measurements in residents' rooms, cooling areas, corridors; Interviews with Complainants, Family Members, Residents, Public Health Inspectors, Acting Manager for COVID response for York Region Public Health, PSW, RPNs, RN, Maintenance Staff, Heavy Duty Supervisor, Director of Environmental Services (DES), District Manager-Compass, Building Services Partner, and Executive Director (ED)] [s. 20. (1.3) (b)]

2. The licensee failed to ensure that every designated cooling area in the home is served by air conditioning which is operated, as necessary, to maintain the temperature in the designated cooling area at a comfortable level for residents during the period and at the times described in subsection 1.3.

The cooling areas in the home were identified by the DES and ED as the dining rooms, and TV or activity rooms on each home area. The indoor air temperature and humidity levels in each dedicated cooling area were to be monitored and logged three times per day (around the hottest peak times of the day) on or around the times before lunch, after lunch, and before dinner, as per the home's Prevention & Management of Heat Related illness policy and Heat Contingency Protocol.

The home's air temperature records between on an identified four-day period, showed:
On the first day, the temperature was between 22 to 27 Celsius (C), the humidity was between 47 to 70%, the humidex ranged from 31 to 37.
On the second day, the temperature ranged from 22 to 29 C, the humidity ranged from 43 to 71%, and the humidex ranged between 27 to 37.
On the third day, the temperature ranged from 24 to 28 C, with humidity ranging from 50 to 76%; the humidex was 28 to 34.
On the fourth day, the temperature ranged between 23 to 28 C, humidity between 47 to 62%; humidex was 28 to 35.

The recorded temperature and humidity between the period, and walk-abouts with the DES and Maintenance staff on the second and third days, showed the temperature and humidity in the designated cooling areas throughout the home were not cooler than the residents' rooms, corridors, or nursing stations.

On the second day, a PSW stated a resident complained it was hot in the TV room. The staff brought residents out of the TV room back to their rooms because it was cooler in residents' rooms than in the TV room. An RPN stated there was no cooling area to bring the residents to, as the dining, TV, and activity rooms felt as hot as the rest of the home, as the regular air conditioning was not working and the portable air conditioners were not yet installed.

On the third day, a resident stated that it was hot in the TV room despite the cooling fan in the room. The Maintenance staff stated they had set up portable air conditioners in the dining rooms on the second and third days, and will continue to install portable air conditioning in the TV rooms in the home.

On the fourth day, a resident's family member stated the resident's room and the TV room were uncomfortable for the resident. They stated the resident's room was too hot even with the new fans installed, and the dining rooms were the only cooler location in the home. They were informed that the dining room capacity was about 20 persons, including staff and visitors, and was concerned where the other residents were able to keep cool. The TV and activity rooms were still not adequately cooled.

Designated cooling areas are to keep residents comfortable and as a part of heat related illness prevention and management. The residents were at risk of potential heat related illness when the designated cooling areas were not served by air conditioning and maintained at a comfortable level for the dates above.

The ED indicated the designated cooling areas were expected to be cooler than the other areas in the home, and the designated cooling areas in the home did have fully operational air conditioning until after the fourth day.

[Sources: A/C Units Audit Forms, Air Temperature Log Forms, Home's Prevention & Management of Heat Related illness policy; Heat Contingency; observations of cooling areas, resident and staff observations, interviews with complainants, family members, residents, PSW, RPN, Maintenance Staff , Heavy Duty Supervisor, Director of Environmental Services (DES), District Manager-Compass, and Executive Director (ED)] [s. 20. (3)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, 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. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

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

A letter was sent to the licensee from Family Council with concerns regarding allegations of physical roughness with residents. A response was provided from the licensee to the Family Council but did not include a response specific to physical roughness with residents.

The home's policy stated suspicion of abuse of a resident by anyone was to immediately report to the ED. The ED or designate should investigate the incident, request that anyone aware of or involved with the situation provide their statements, and ensure statements were obtained as close to the time of the event as possible. The alleged team member(s) would be sent home pending investigation and the appropriate authorities would be contacted.

The ED indicated that a complaint regarding physical roughness with residents should be reported to the ED as it was related to abuse. The complainant should have been contacted to gather details of the allegation, and the DOC should have begun the investigation. The ED indicated they had not received the identified letter, as it was directed to the licensee, and they were not informed of the allegations of physical roughness towards residents, was aware of the affected residents or the time frame of the allegation.

The Corporate Vice President of Regional Operations indicated that a response was provided to the complainant four days after the letter was received, however, they did not know which residents or the time frame of the allegation.

The ED indicated that policies and procedures regarding clarification with the complainant, reporting to the ED or designate, gathering statements with anyone aware of the incident, and the investigation were not followed, which placed a risk of delayed action in preventing the abuse or neglect of residents.

[Sources: Prevention of Abuse & Neglect of a Resident Policy, Complaints Management Program (ON) Policy, interviews with complainants, family members, Executive Director (ED), and Corporate Vice-President of Regional Operations] [s. 20. (1)]

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 policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
3. Every designated cooling area, if there are any in the home. O. Reg. 79/10, s. 21 (2).

s. 21. (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. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature was measured and documented in writing in every designated cooling area.

The home had designated cooling areas identified in each home area. The home's temperature logs showed that temperature measurements did not include every designated cooling area on all shifts on three identified day. On the fourth day, the morning and afternoon temperature logs did not include every designated cooling area. On the fifth day, the morning temperature log did not include measurements for every designated cooling area.

The A/C Units Audit and Air Temperature Logs indicated that staff should inform the nurse in charge of intervention or emergency alert as required per chart, based on the indoor temperature and humidity readings. Without taking the appropriate temperature measurements of designated cooling areas, there was a risk that any hot temperature and cooling-related concerns in designated cooling areas would not be identified in a timely manner, that alerts to the nursing staff would not be done, and appropriate interventions not implemented.

The DES and ED stated the staff should have recorded the temperature and humidity reading for every designated cooling area, and this was not done on the identified times above.

[Sources: Home's Prevention & Management of Heat Related illness policy, Air Temperature log forms, A/C Units Audit form; Interviews with Maintenance Staff, Heavy Duty Supervisor, Director of Environmental Services (DES), District Manager-Compass, and Executive Director (ED)] [s. 21. (2) 3.]

2. The licensee has failed to ensure the temperature required to be measured was documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

As of May 15, 2021, in accordance with Ontario Regulations 79/10 (O. Reg 79/10), the licensee was required to measure the temperature and document temperature readings of at least two resident bedrooms in different parts of the home, one resident common area on every floor of the home, and every designated cooling areas three times daily during the above mentioned periods.

Between May 15 to June 4, 2021, the home had only recorded the air temperature once daily in the morning.

The DES indicated the air temperature measurement had only been done once daily but should be increased as the temperature gets hotter.

The ED stated the measurement and documentation frequency was not done in accordance with the Ministry's requirements.

[Sources: A/C Units Audit logs, Air Temperature logs, observation of air temperature measurement process; Interviews with complainants, family

members, Maintenance Staff, Heavy Duty Supervisor, Director of Environmental Services (DES), District Manager-Compass, Executive Director (ED)] [s. 21. (3)]

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 temperature measured and documented
1) for every designated cooling area, and
2) temperature of the required areas areas measured and documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used the handheld thermohygrometer in accordance with manufacturers' instructions.

A handheld non-contact digital infrared temperature thermometer was used to measure the ambient temperature and humidity in residents' rooms and cooling areas.

The manual directed that when the working environment experiences sudden change, the meter must be placed in an environment for 30 minutes and resume measurement only when the temperature inside the meter is consistent with that outside it.

The DES and maintenance staff spent approximately 10 to 30 seconds in the room to take temperature and humidity measurements.

The maintenance staff took the measurement standing outside the room and pointed at the opposite wall. The DES and Heavy Duty supervisor took measurements standing in the middle of the room and pointed to the ceiling.

The DES indicated there were two wall thermohygrometers in the corridors of each unit, but only one handheld thermohygrometer to take measurements in all residents' rooms and designated cooling areas, which was used to measure the residents' rooms, common areas, and designated cooling areas. The meter would experience sudden changes in temperature as it was moved from room to room and unit to unit, where the areas were at different temperatures.

The District Manager stated the meter should remain in the room for the time indicated in the manual to accurately measure the ambient temperature, and the staff did not use the meter in accordance manufacturer's instructions.

[Sources: Air-temperature log forms – maintenance, Non-contact infrared thermometer users' manual; Observation of non-contact infrared thermometer, measurements taken in units in the home; Interviews with Maintenance Staff, Heavy Duty Supervisor, Director of Environmental Services (DES), District Manager-Compass, and Executive Director] [s. 23.]

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 staff use all devices in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
11. Seasonal risk relating to heat related illness, including protective measures required to prevent or mitigate heat related illness. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care related to seasonal heat risk was developed utilizing an interdisciplinary assessment for three residents.

A resident was diagnosed with acute dehydration. The resident was subsequently sent to hospital for elevated blood sodium levels and returned home with a new diagnosis and a drug was initiated to treat the condition.

The resident required one-person physical assistance and was at high nutritional risk.

The resident's heat risk assessment prior to the incident showed that the resident's risk for heat related illness was low. The resident's clinical health record did not show that any other interdisciplinary team member was involved in development of the resident's plan of care related to their risk of heat related illness when the care plan focus was created.

The resident returned to the home, and their plan of care did not include a reassessment of the resident's heat risk despite the resident having a new diagnosis and dehydration, or conditions that placed the resident at an increased risk for having heat related illnesses.

The scope was expanded to include two other residents when a non-compliance was identified for the first resident.

The second resident was on a modified texture diet with thickened fluids. The resident's heat risk level indicated that the resident was at low heat risk. The resident's clinical health record did not show that any other member of the interdisciplinary team was involved in development of the resident's plan of care related to their risk of heat related illness.

The third resident's care plan indicated that the resident's heat risk level was high. The interventions included: Encourage cool/cold fluids to keep them hydrated, reminder to not be outside during hot weather episodes, keep in a cool environment, and help them wear light/cool clothes during hot weather.

Further review of the resident's clinical health record did not show that any other member of the interdisciplinary team was involved in development of the resident's plan of care related to their risk of heat related illness.

According to the Guidelines for the Prevention and Management of Hot Weather-Related Illness in Long-Term Care Homes, released by the Ministry of Long-term Care, indicated, "Residents' risk of developing adverse effects due to heat exposure is subject to a number of variables such as the ambient temperature and humidity in the home, health and functional status, clothing and level of activity, hydration and nutrition."

The home's PCC heat risk assessment used in the home did not include information regarding residents' hydration and nutrition status, clothing, or activity level.

The Registered Dietitian (RD) indicated that they would review residents' risk levels after the heat risk assessment was completed by registered staff, and prioritize the residents who were determined to be high risk, then continue with the moderate and low risk residents and would review the resident's food and fluid

intake, their nutritional risks and update the care plan.

An RN indicated that the plan of care related to seasonal heat risk was developed utilizing the heat risk assessment. A referral to the RD would only be made if there was a significant change to the resident. They indicated that the home's current heat risk assessment was not adequate to develop a plan of care.

The DOC indicated that, for the above-mentioned three residents, the plan of care was not based on an interdisciplinary assessment of the resident.

[Sources: Residents' progress notes, heat risk assessments, MDS assessments, care plans; Interviews with DOC, RD, RN and relevant staff members.] [s. 26. (3) 11.]

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 a plan of care related to seasonal heat risk is developed using an interdisciplinary assessment for residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, when the Family Council has advised the licensee of concerns or recommendations, the licensee would respond to the Family Council in writing within 10 days of receiving the advice.

A letter dated was sent to the licensee from Family Council with identified concerns. A subsequent letter dated 14 days later, was sent to the licensee from Family Council with additional concerns and stated a response was not received regarding the letter from Family Council.

The Vice President of Regional Operations stated that the letter was written on behalf of Family Council, and it would be responded to based on the policy and regulation for responding to Family Council. They stated no other documented response from the home or licensee to Family Council was found for a period of 16 days since the letter was sent.

The licensee had not responded to the Family Council within 10 days of receiving the Family Council advice for the identified letter.

[Sources: Family Council policy, Complaints Management Program (ON) Policy, interviews with complainant, Executive Director (ED), and Vice President of Regional Operations of Sienna Senior Living] [s. 60. (2)]

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, if the Family Council has advised the licensee of concerns or recommendations, the licensee shall respond to the Family Council in writing within 10 days of receiving the advice, to be implemented voluntarily.

WN #8: 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,
(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).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that heating, ventilation and air conditioning systems were inspected at least every six months by a certified individual, and that documentation was kept of the inspection.

Two scheduled contract HVAC maintenance was done by Single Source Mechanical service, but there was a seven-month gap between the time of the two scheduled maintenance inspection.

The DES was to ensure the Heating, Ventilation and Air Conditioning (HVAC) contractor inspection reports were received indicating which units were inspected, and make sure reports that identified deficiencies had corrective actions taken, and listed the recommended repairs. The contractor was to meet with the DES to review work to be performed prior to, and after the completion of the work. The DES was to sign off completion of the work after and obtain a copy of the completed work order.

The previous DES recalled contractors coming in but was unable to recall when the scheduled maintenance was performed between the seven-month period or produce any documentation of the scheduled maintenance.

The District Manager indicated the contract HVAC preventative maintenance was to happen four times per year. The current DES began to work in the home at the start of the seven-month period and did not have the documentation of the scheduled maintenance work performed. The DES and Sienna Building Services Partner contacted the contractor, who not able to provide documentation of scheduled maintenance. The DES indicated the scheduled inspection document should have been kept, but it was not.

[Sources: Single Source Mechanical Work Orders, HVAC Preventative Maintenance Services – Schedule 2 Statement of Work, Preventative maintenance task schedule, HVAC Contractor Inspection Reports Policy, HVAC Equipment Maintenance – Roof Mounted ; Interviews with Director of Environmental Services (DES), District Manager-Compass, Sienna Building Services Partner, and Executive Director (ED)] [s. 90. (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 procedures are developed and implemented to ensure that heating, ventilation and air conditioning systems are inspected at least every six months by a certified individual, and that documentation is kept of the inspection., to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 92. Designated lead — housekeeping, laundry, maintenance

Specifically failed to comply with the following:

s. 92. (2) The designated lead must have,
(a) a post-secondary degree or diploma; O. Reg. 79/10, s. 92 (2).
(b) knowledge of evidence-based practices and, if there are none, prevailing practices relating to housekeeping, laundry and maintenance, as applicable; and O. Reg. 79/10, s. 92 (2).
(c) a minimum of two years experience in a managerial or supervisory capacity. O. Reg. 79/10, s. 92 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the designated lead for housekeeping, laundry, and maintenance had a minimum of two years' experience in a managerial or supervisory capacity.

The DES indicated that they were the designated lead for laundry, housekeeping, and environmental services in the home, and had worked in the home for one month. Their combined supervisory and managerial experience was under two years.

The ED's review of the DES' resume verified the DES did not have the required supervisory and managerial experience. The ED acknowledge that the DES did not meet the requirement for the designated lead for housekeeping, laundry, and maintenance.

[Sources: Long-Term Care Homes Act, 2007 – Ontario Regulation 79/10, Director of Environmental Services (DES) resume; Interviews with Director of Environmental Services (DES), District Manager Compass, and Executive Director (ED)] [s. 92. (2)]

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 designated lead for housekeeping, laundry, and maintenance has a minimum of two years' experience in a managerial or supervisory capacity, to be implemented voluntarily.

Issued on this 3 rd day of September, 2021 (A2)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by IVY LAM (646) - (A2)
Inspection No. / No de l'inspection :	2021_769646_0011 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	008846-21 (A2)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 02, 2021(A2)
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, Markham, ON, L3R-0E8
LTC Home / Foyer de SLD :	Woodbridge Vista Care Community 5400 Steeles Avenue West, Woodbridge, ON, L4L-9S1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sarah Bendo

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19 of the LTCHA.

Specifically, the licensee shall prepare, submit and implement a plan to ensure that residents are not neglected by staff.

This plan must include:

1) Training of all registered staff and personal support workers on accurate documentation of fluids served to a resident. A record must be kept of the training that was provided, who provided the training and staff that completed the training.

2) The development of an auditing tool to ensure that staff are accurately documenting fluid intakes of residents. This audit must include an observation of either a snack or meal service. The audit must include resident names, names of staff audited, date of the audit, name of the auditor, issues identified and what corrective actions were taken. This audit must be done every month on one resident on each floor until the audit results are 100% for three consecutive months. Audit results must be available to the Inspector if requested.

3) Develop an interdisciplinary approach to assess, identify, and address significant changes related to dehydration for all residents.

Please submit the written plan for achieving compliance to Ivy Lam (646), LTC Homes Inspector, MLTC, by email to ivy.lam@ontario.ca by August 27, 2021.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure that a resident was protected from neglect.

As per O. Reg. 79/10, s. 5, the definition of "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health,

safety or well-being of one or more residents.

The home submitted a Critical Incident System (CIS) report related to a resident being found seated in soiled clothing, with a dirty assistive mobility device, and severely dehydrated. A complaint was additionally forwarded to the Ministry of Long-term Care (MLTC) related to the above concerns.

The resident's family member stated that they called into the home almost daily to ask the staff about the resident's fluid and meal intake and general health condition. They were informed that the resident's intake was good and the home did not indicate any concerns about the resident's intake. The family member later found the resident unkempt with dried food on their clothes, and the assistive mobility device dirty. The family indicated that they informed the charge nurse of the condition they found the resident in and had previous concerns about the resident's hygiene and cleanliness prior to this date.

The inspector reviewed images that were taken by the resident's family member and observed a substance was noted on the resident's shoulder and hair, scaly skin around their mouth, and stains on the resident's sweater, pants and assistive mobility device.

A Registered Practical Nurse (RPN) informed the resident's family member that they would continue to monitor the resident. Six days later, the resident's Substitute Decision Maker (SDM) reported that the resident appeared weaker, in pain and was unable to reposition themselves in their assistive mobility device. A referral was made to physiotherapy, pain monitoring and a urine culture and sensitivity was ordered by the Nurse Practitioner (NP) during the day shift. That same evening, the RPN noted that the resident was sleepier than usual and was gurgling their fluids. The RPN took the resident's vital signs which showed a change in the resident's blood pressure in the afternoon compared to the morning blood pressure. The RPN left a note for the physician to follow up the next day. No other additional assessments were completed related to the resident's lethargy or gurgling of fluids, nor was the on-call physician notified.

The next day, the physician was completing their rounds and observed that the resident was lethargic and slumped in their assistive mobility device. An assessment showed the resident continued to experience a change in their BP from baseline, had

dry oral mucosa and was lethargic. The physician determined that the resident was clinically dehydrated, initiated hypodermoclysis and ordered bloodwork. The resident was sent to hospital three days later, as their bloodwork showed elevated levels of sodium and chloride, and low levels of potassium. In the hospital, the resident's blood sugar was abnormally high. The resident had no history of the health condition prior to the hospital admission, but returned to the home with a new diagnosis and new medication.

A week prior to the resident's diagnosis of dehydration, a Personal Support Worker (PSW) indicated they had observed the resident with declined in energy levels, required more assistance and had a decrease in food intake. The PSW indicated that they observed the resident to be in pain and reported this to the nurse. The progress notes on the day they reported did not show that a pain assessment was completed.

The resident's fluid intake documentation showed that the resident had met and sometimes exceeded, their required fluid intake for the time period that they were identified with dehydration. Observations of the resident's meal intake showed that resident had suboptimal intake at most meals, and they had fully consumed their oral nutritional supplement. There was no consistent documentation noted to identify the exact percentage of the meal the resident had consumed.

An RPN student indicated that during a meal service service, the resident had 0.5 servings of fluid. The documentation for that day showed that a total of 1.5 servings was given to the resident at that meal service.

Observations the next day during a meal service showed indicated the resident had consumed one serving of juice, 120 milliliters (mls) of oral nutritional supplement and 20% of another fluid for a total of 2.2 servings. The documentation for the same meal service that day, indicated the resident received 3.7 servings. The staff had not consistently and accurately documented the resident's fluid intake, which increased the risk of inaccurate assessment of fluid intake.

On four separate days, a PSW reported to the registered staff that the resident did not eat their meal. On three other days, the resident's intake was consistently at or below 50%. Registered staff relied on an alerting system in PointClickCare (PCC) to indicate to them when a resident had consumed less than 50% at meals. The progress notes did not show any additional assessments or monitoring was initiated

for the resident during the abovementioned period.

The resident's care plan after the resident returned from hospital did not show any changes or revisions to interventions related to their hydration status; their risk for heat related illnesses was not reviewed and was not based on an interdisciplinary assessment.

The Physician and Director of Care (DOC) indicated that there were inconsistencies with the resident's fluid intake. The Physician #120 indicated that to have a resident dehydrated was negligent as staff were required to monitor residents for dehydration.

The DOC indicated that staff were required to complete a full assessment on the resident when they were observed a change in health status, which had occurred twide for the resident during the abovementioned period, which included contacting the on-call physician. Based on the home's investigation, the DOC determined that the resident was neglected when the Registered staff had not completed a full assessment when the resident had a change in health status.

[Sources: Review of Critical Incident System (CIS) report, home's investigation notes, progress notes, care plan, point of care documentation, documentation survey reports; Observations of resident and staff; Interviews with complainant, Physician, DOC, PSW, RPN student, and other relevant staff.]

The severity of this issue was determined as serious harm to the resident as they received a diagnosis of dehydration and diabetes.

The scope of the issue determined to be isolated, as it affected one out of three residents reviewed.

The home had previous non-compliances to the same subsection in the last 36 months. The home's compliance history included the following non-compliance with the same subsection that included:
- WN on March 8, 2021 (2021_808535_0002) for s.19.(1).
- WN on September 18, 2020 (2020_780699_0011) for s.19.(1).
- WN on September 18, 2020 (2020_780699_0013) for s.19.(1).
- WN on May 13, 2021 (2021_780699_0008) for s.19.(1).
- DR on September 11, 2020 (2020_780699_0014) for s.19.(1). (699)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 18, 2021(A2)

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

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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 20. (1.3) 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 21 (2) and (3) reaches 26 degrees Celsius or above, for the remainder of the day and the following day. O. Reg. 79/10, s. 20 (1.3).

Order / Ordre :

The licensee must comply with s. 20. (1.3) of the O. Reg 79/10.

Specifically, the licensee shall prepare, submit and implement a plan to ensure the home's home's heat related illness prevention and management plan is implemented between May 15 to September 15, and on any day or other time as specified under s. 20 (1.3) (a) and (b).

The plan must include:

1) Training of all registered staff and personal support workers (PSWs) and all maintenance team members to be made aware of the different interventions used in the home's summertime practice compared to an intervention alert and implement these interventions.

2) Identification of the manufacturer's instructions for the thermometer and/or thermohygrometer device(s). Training of all staff members responsible for measuring and recording the home's air temperature to follow the instructions for measuring the air temperature.

3) The prescribed air temperature form is used by any staff after measuring the air temperature log, and that staff perform and document all items as directed on the form.

4) Development and implementation of a communication system to allow registered staff, PSWs, maintenance staff, and dietary staff on all shifts to be aware of the home's current heat contingency protocol status, and to perform their specific roles based on the status.

5) Education to the maintenance and registered staff of the escalation process to the ED when the interventions to be used are not available or fully operational, or are not able to cool residents as expected, and that staff follow this process.

6) A record kept of times when the home was on intervention and/or emergency alert between June 18 to September 15, 2021, and what interventions were provided.

7) Development and audits on items 1) to 5) for two months or until the concerns identified are resolved. Keep a record of the completed audits.

Please submit the written plan for achieving compliance to Ivy Lam (646), LTC Homes Inspector, MLTC, by email to ivy.lam@ontario.ca by August 27, 2021.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to ensure that the heat related illness prevention and management plan for the home was implemented by the licensee during the period from May 15 to June 9, 2021; and anytime the temperature in an area in the home measured by the licensee reached 26 degrees Celsius or above, for the remainder of the day and the following day.

As per the home's policy, summertime practice was to be implemented in the home when the relative humidity was less than 50% and the indoor temperature was

between 23-26%. The maintenance staff were to record the indoor temperature and humidity percentage on the Air Temperature Log and inform all departments of the heat contingency protocols to be implemented. They were also to ensure at least one separate designated cooling area was available for every 40 residents. Hot weather protocols for nurses and PSWs included monitoring all residents for signs and symptoms of heat related illness, and to ensure water and cold drinks were available and easily accessible.

When the relative humidity in the home was greater than 50% and the indoor temperature was 26.1-32 degrees Celsius (C), or when the relative humidity was less than 50% and the indoor temperature was 28-34 degrees C, an intervention alert should have been issued. The maintenance team was to continue previous measures and collaborate with the Executive Director (ED) to determine the need to move residents to a common air conditioned/cooling area and ensure all in-room air conditioners were working. The nursing team were to offer increased fluids, ensure if a fan was used in a resident's room, it was not blowing directly on a resident. The residents should have been encouraged to move to an area in the home with air conditioning.

The Air Temperature Log form was updated to remind the staff members who took the temperature recordings to notify the charge nurse, to take action for elevated temperatures recorded, and to escalate heat concerns to the ED. The form was provided to the Director of Environmental Services (DES) on an identified day. The DES provided the form to the maintenance team members four days later, but the form was not used by all maintenance team members until more than one month after.

The maintenance team members were observed to take temperature and humidity measurements in the home using one handheld thermohygrometer. The handheld device was stored in the basement or in the DES' office, and the one handheld device was shared on all home areas. The thermohygrometer was not left in the room environment for the appropriate length of time in accordance with manufacturer's instructions.

On an identified day, the temperature on three floors in the home reached 26 degrees C with humidity of 51%. A Maintenance staff indicated they did not alert the nurse in charge but had submitted the temperature log to their manager. The DES

stated they had received the log but the temperature was acceptable in their opinion and the home remained in summertime practice.

The next day, the afternoon temperature and humidity recordings on two floors reached intervention alert with the temperature between 26.4-28.1 degrees C and humidity of 47-54%, with the humidex ranging from 31-32. The nighttime temperature reached intervention alert levels on all units, with room temperatures ranging from 26 -29 degrees C, humidity ranging 52-62%, and humidex 30-37. A PSW and RPN stated the building was hot that day, but there was nowhere to bring the residents to for cooling, as there was no air conditioning in the dining, TV, and activity rooms.

The Maintenance staff and the heavy-duty supervisor who took the temperatures on the second day, indicated they had not communicated about the temperature or humidity levels to the charge nurses, but had submitted the temperature logs to the DES and the ED. The DES indicated they had not communicated an intervention alert to the charge nurses that day, as the heavy-duty supervisor told them they had already communicated the intervention alert to the charge nurse. Registered staff working on day, evening, and night shifts indicated they saw maintenance team members take the temperature, but the staff did not inform them of the temperature and humidity or any level of alert. They further stated there were no shift reports indicating intervention alert in the home.

On the third day, the temperature and humidity recordings on all units reached intervention alert. The Maintenance staff stated they had taken the temperature and humidity measurements. They indicated it was the maintenance staff or the DES' responsibility to inform the nurses of the heat in residents' rooms and to suggest moving residents to another location, but they did not inform the nurses because they did not have time. The RPN stated they continued summertime practice and was not informed by the maintenance staff or any manager of an intervention alert, but would rely on their nursing judgment or the PSWs' request to provide additional interventions.

On the third day, a resident was found in their room with a room temperature of 28 degrees C and humidity of 83%. On the fourth day, the resident was found in their room, with a room temperature of 27 degrees C and humidity of 84%. Two fans were directed at the resident, with one fan facing the entrance, with the stream of air flowing to the resident and directly towards the room entrance. A PSW indicated the

resident had a condition which required them to remain in their room, but they had provided an extra fan for the resident. They stated they had not provided the resident with additional fluids beyond their regular fluids, as the resident consumed their fluids well at meals and snack times. They would encourage additional fluids if the resident did not complete their scheduled fluids.

The DES and the District Manager for environmental services indicated cooling fans were provided for the resident, but the communication process of the air temperature heat alert levels between the maintenance and the nursing team was still in development and not properly implemented until July 9, 2021.

Interviews with PSWs, RPNs and the Registered Nurse (RN) between the second to fourth days, showed the staff members were not aware of the difference between summertime practices and intervention alerts. They were not aware of any additional measures needed during an intervention alert. The nurses did not know how to take indoor temperature and humidity readings, were not aware of where the thermohygrometer was located, or where to find the Air Temperature Log. They were not aware that, according to the policy, they were to measure the indoor air temperature/humidity in the absence of maintenance team members.

The DOC indicated education on the updated policy and heat contingency protocol was provided for 25 registered staff and PSWs on the second day and continued to provide the education to other staff. Nurses were to receive intervention alerts from the maintenance staff based on the temperature and humidity measurements, and additional interventions would be provided. They further indicated the registered staff and maintenance staff should have escalated the heat concerns to the appropriate managers to identify and relocate residents to cooler areas in the home when the home reached an intervention alert and the designated cooling areas were not cooler than the residents' rooms. They stated that the identified resident should have been brought to a cooler area or the registered staff should have requested an additional cooling unit be provided in the resident's room. The ED indicated the fan should not be aimed directly at the resident, and should not be blowing towards the door entrance, and that this had been corrected. Registered staff should also have been aware of the heat contingency protocol, including the additional steps and communication needed for an intervention alert.

The ED indicated the maintenance team were expected to use the Air Temperature

Log form on or after the day it was provided to the DES, and the DES was to ensure the maintenance staff communicate appropriate heat alerts to the nursing staff. The maintenance team or DES should have escalated the concerns to the ED or a manager-on-call when the cooling fans were provided to residents, but the home remained in intervention alert level, to discuss the need to relocate residents to cooler areas in the home until the designated cooling areas were operational.

The home's heat related illness prevention and management plan was not fully implemented during the period beginning May 15, 2021. There was a potential risk of heat-related illness to the residents during this period.

[Sources: Home's Prevention & Management of Heat Related illness policy, Heat Contingency Protocol, Hot Weather Cooling Areas policy attachment, A/C Units Audit Forms, Air Temperature Log Forms; Observations of residents' rooms, observations of cooling areas, resident and staff observations, thermohygrometer measurements in residents' rooms, cooling areas, corridors; Interviews with Complainants, Family Members, Residents, Public Health Inspectors, Acting Manager for COVID response for York Region Public Health, PSW, RPNs, RN, Maintenance Staff, Heavy Duty Supervisor, Director of Environmental Services (DES), District Manager-Compass, Building Services Partner, and Executive Director (ED)] [s. 20. (1.3) (b)]

2. The licensee failed to ensure that every designated cooling area in the home is served by air conditioning which is operated, as necessary, to maintain the temperature in the designated cooling area at a comfortable level for residents during the period and at the times described in subsection 1.3.

The cooling areas in the home were identified by the DES and ED as the dining rooms, and TV or activity rooms on each home area. The indoor air temperature and humidity levels in each dedicated cooling area were to be monitored and logged three times per day (around the hottest peak times of the day) on or around the times before lunch, after lunch, and before dinner, as per the home's Prevention & Management of Heat Related illness policy and Heat Contingency Protocol.

The home's air temperature records between on an identified four-day period, showed:
On the first day, the temperature was between 22 to 27 Celsius (C), the humidity was between 47 to 70%, the humidex ranged from 31 to 37.

On the second day, the temperature ranged from 22 to 29 C, the humidity ranged from 43 to 71%, and the humidex ranged between 27 to 37.
On the third day, the temperature ranged from 24 to 28 C, with humidity ranging from 50 to 76%; the humidex was 28 to 34.
On the fourth day, the temperature ranged between 23 to 28 C, humidity between 47 to 62%; humidex was 28 to 35.

The recorded temperature and humidity between the period, and walk-abouts with the DES and Maintenance staff on the second and third days, showed the temperature and humidity in the designated cooling areas throughout the home were not cooler than the residents' rooms, corridors, or nursing stations.

On the second day, a PSW stated a resident complained it was hot in the TV room. The staff brought residents out of the TV room back to their rooms because it was cooler in residents' rooms than in the TV room. An RPN stated there was no cooling area to bring the residents to, as the dining, TV, and activity rooms felt as hot as the rest of the home, as the regular air conditioning was not working and the portable air conditioners were not yet installed.

On the third day, a resident stated that it was hot in the TV room despite the cooling fan in the room. The Maintenance staff stated they had set up portable air conditioners in the dining rooms on the second and third days, and will continue to install portable air conditioning in the TV rooms in the home.

On the fourth day, a resident's family member stated the resident's room and the TV room were uncomfortable for the resident. They stated the resident's room was too hot even with the new fans installed, and the dining rooms were the only cooler location in the home. They were informed that the dining room capacity was about 20 persons, including staff and visitors, and was concerned where the other residents were able to keep cool. The TV and activity rooms were still not adequately cooled.

Designated cooling areas are to keep residents comfortable and as a part of heat related illness prevention and management. The residents were at risk of potential heat related illness when the designated cooling areas were not served by air conditioning and maintained at a comfortable level for the dates above.

The ED indicated the designated cooling areas were expected to be cooler than the

other areas in the home, and the designated cooling areas in the home did have fully operational air conditioning until after the fourth day.

[Sources: A/C Units Audit Forms, Air Temperature Log Forms, Home's Prevention & Management of Heat Related illness policy; Heat Contingency; observations of cooling areas, resident and staff observations, interviews with complainants, family members, residents, PSW, RPN, Maintenance Staff , Heavy Duty Supervisor, Director of Environmental Services (DES), District Manager-Compass, and Executive Director (ED)]

The severity of this issue was determined as potential risk of heat-related illness to the residents when home's heat related illness prevention and management plan was not fully implemented during the period above-mentioned period.

The scope of the issue determined to be widespread, as it affected seven out of seven home areas inspected.

The home had previous non-compliances to different subsections in the last 36 months. (646)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 18, 2021(A2)

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

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

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 3 rd day of September, 2021 (A2)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by IVY LAM (646) - (A2)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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