Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 8, 2018	2018_626501_0011	015872-18	Complaint

Licensee/Titulaire de permis

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

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

Silverthorn Care Community
4350 Mississauga Road MISSISSAUGA ON L5M 7C8

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

SUSAN SEMEREDY (501)

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): July 10 and 11, 2018. Additionally, off-site interviews were conducted July 12 and 13, 2018.

During this inspection the following intake was inspected:
Intake #015872-18 related to the temperature of the home and maintenance of the windows.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Directors of Care (ADOCs), Director of Environmental Services (DES), registered nurse (RN), personal support workers (PSWs), substitute decision-maker (SDM), residents and the home's heating, ventilation and air conditioning (HVAC) contractors.

During the course of this inspection the inspector observed staff and resident interactions and reviewed health records, relevant policies and procedures, temperature logs and HVAC work orders.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Safe and Secure Home

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

- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written hot weather related illness prevention and management plan that meets the needs of the residents was implemented when required to address the adverse effects on residents related to heat.

A review of a complaint intake identified that a Substitute Decision Maker (SDM) visited the home on an identified date, and found that the home's air-conditioning was not working properly. The SDM stated resident #001 was dressed in unsuitable clothing.

During an interview with PSW #107, they stated they worked the day after on the same weekend, and had heard that resident #001's SDM had complained about the heat and that resident #001 was dressed in identified clothing. PSW #107 stated that on that day the home was uncomfortably warm. During an interview with PSW #108, they stated they worked that day and recalled dressing resident #001 in identified clothing and that later in the day they noticed the home was getting warm.

Review of the home's written and verbal complaints spreadsheet indicated two family members complained about the heat on an identified date and the Director of Environmental Services (DES) came to the building and contacted the home's Heating, Ventilation and Air Conditioning (HVAC) contractors who came into the building to make repairs.

During an interview with the DES, they stated they were on holidays and came to the home on an identified date because they were contacted by the Executive Director (ED) that the building was hot on certain units. The DES found that some HVAC units were not working and upon inspection of the building automation system, they discovered that some areas of the home had reached 78 degrees Fahrenheit (25.6 degrees Celsius). The DES called their HVAC contractors who found that the coils needed to be washed with an acid bath. Review of work orders from the HVAC contractor identified that the company came to the home on identified dates and conducted identified repairs and services including power washing.

Review of the home's policy #VII-G-10.10 "Hot Weather – Management of Risk" revised November 2015, indicated the role of the PSW is to dress residents in light clothing. An attachment to this policy #VII-G-10.10(a) titled "Heat Contingency Protocols" indicated that summertime practices include maintenance being responsible to record indoor temperature and humidity percentage from various locations within the building daily, and

document temperatures on the electronic computerized maintenance system or Air Temperature Log. The registered staff member is to ensure that in the absence of maintenance, the indoor air temperature/humidity is taken from various locations within the building daily and documented in the Air Temperature Log. According to this protocol temperature/humidity is measured using a wet bulb globe thermometer or a thermohygrometer, which measures air temperature and humidity.

During an interview with maintenance worker #105, they stated that they record indoor temperatures from various locations within the building but do not record humidity percentages. Review of temperature readings for June and July 2018, indicated not all days were being monitored and weekends were not included. According to the maintenance worker, no one takes the temperatures of the home when they are not there.

During an interview with RN #106, who was in charge, there was no one monitoring the temperature of the home that weekend. RN #106 thought maintenance monitored the temperature on the weekends but recalled that there was no one from maintenance working that weekend.

During an interview with the Director of Care (DOC) and ED, they acknowledged that the home was not following their hot weather protocol of recording indoor temperature and humidity percentage from various locations within the home daily. They also stated they were unaware that the home was hot on an identified date but could not verify this as there were no temperatures recorded. They indicated resident #001 was dressed in identified clothing but did not think the resident was dressed inappropriately.

Not taking temperature and humidity readings of the home the identified weekend when the air conditioning system malfunctioned, did not ensure that the home's written hot weather related illness prevention and management plan that meets the needs of the residents was implemented when required to address the adverse effects on residents related to heat. [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 home's written hot weather related illness prevention and management plan that meets the needs of the residents is implemented when required to address the adverse effects on residents related to heat, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(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 implemented to ensure that the heating, ventilation and air conditioning systems were cleaned.

A review of a complaint intake identified that a Substitute Decision Maker (SDM) visited the home on an identified date, and found that the home's air-conditioning was not working properly.

During an interview with the DES, they stated they were on holidays on the above weekend but came to the home because they were contacted by the ED that the building was hot on certain units. The DES found that some HVAC units were not working and upon inspection of the building automation system, they discovered that some areas of the home had reached 78 degrees Fahrenheit (25.6 degrees Celsius). The DES called their HVAC contractors who found that the coils needed to be washed with an acid bath. Review of work orders from the HVAC contractor identified that the company came to the home on identified dates and conducted repairs and services including power washing.

During an interview with one of the owners of the home's HVAC contractor, they stated that for many of the long-term care homes that they service, only a small number opt to have the cleaning of the coils completed. According to the contractor, cleaning of these coils entails a special high pressure washer and the use of special chemicals.

A further interview with another of the owners of the contractor who oversees the contract for the home was conducted. In this interview, they confirmed to the Inspector that the primary issue on the above identified date, was that the condenser coils needed power washing. They also indicated that although there was evidence that the home had tried to power wash these condenser coils, it was not adequate.[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 implemented to ensure that the heating, ventilation and air conditioning systems are cleaned, to be implemented voluntarily.

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Issued on this 13th day of August, 2018

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

Original report signed by the inspector.