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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 31, 2018	2018_491647_0001	000080-18	Critical Incident System

Licensee/Titulaire de permis

THE ONTARIO MISSION OF THE DEAF
2395 BAYVIEW AVENUE NORTH YORK ON M2L 1A2

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

BOB RUMBALL HOME FOR THE DEAF
1 Royal Parkside Drive BARRIE ON L4M 0C4

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

JENNIFER BROWN (647)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 2, 3 and 4, 2018

The following critical incident was inspected:
#000080-18 related to failure/breakdown of major system - heating

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Nurse Manager (NM), Manager of Nutrition and Environmental Services, Registered Nurses (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW) and Residents.

During the course of the inspection, the inspector conducted observation in home and resident areas, including temperatures of resident areas, and review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **2 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. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is maintained as a minimum temperature of 22 degrees Celsius (C).

Review of intake #000080-18 revealed the home contacted the Ministry of Health and Long Term Care (MOHLTC) on an identified date, indicating a lack of heat in the home,

and subsequently submitted Critical Incident Report (CI) on an identified date. The CI indicated that the loss of heat was related to a failure/breakdown of the home's heating system due to a breakdown of the automatic controller that operated an identified care centre.

A review of the above mentioned CI indicated that on an identified date, the temperatures of the home had begun to drop, therefore, space heaters had been purchased for all identified resident rooms to maintain a temperature of 22 C, until a repair could be completed. A further review of the CI indicated that flow sheets had been developed and nursing monitored temperatures every half hour in each resident room.

A review of a memo written by the Administrator, directed staff to check each room every half hour and record the temperature to ensure that 22 C was maintained.

A record review of the half hour temperature log sheet was conducted. The documented temperatures recorded for an identified date indicated that 21 out of the affected resident rooms remained less than the required temperature and ranged between 14.7-21.3 C.

On an identified date, the resident room temperatures had continued to not reach the required temperature of 22 C, and 28 out of the affected resident rooms continued to drop in temperature and ranged from 14.7-20.2C.

At no time between the first identified date and the second identified date, were any identified resident rooms maintained at 22 C, and had been confirmed during an interview with the Manager of Nutrition and Environmental Services and the Director of Care.

An interview with Registered staff #104 and #105, who had both worked during the affected period of time, indicated they were directed to take temperatures of each resident room every half hour and set the individual space heaters on low to maintain a temperature of 22 C. The identified staff further indicated that if the temperature was not maintained at the required temperature, Registered staff #104 and #105 had been directed to turn the heater up until the temperature would reach 22 C. The above mentioned staff indicated they did not have time to monitor each room every half hour as directed, and further indicated that when they did, the rooms had continued to be cold.

Interview with the Director of Care (DOC) indicated the above documented temperatures indicated above had been accurate and confirmed that the interventions of using space

heaters had been ineffective in ensuring the home and all resident rooms on the affected care centres were maintained at a minimum temperature of 22 C and continued to decline. The DOC indicated the home had not been prepared for the breaker panel issue as a result of plugging 32 space heaters in to the electrical outlets.

A compliance order will be served to the home based on the scope, which is widespread as it involves more than one home area. More than a few residents were affected and the severity of the non-compliance had the potential to negatively affect residents as the temperatures on the affected home areas and had not been maintained as required. The home's monitoring plan also failed to implement measures to ensure that resident rooms were maintained at 22 C. There is no previous compliance history for this legislative reference. [s. 21.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (4) The licensee shall ensure that the emergency plans provide for the following:
1. Dealing with,
i. fires,
ii. community disasters,
iii. violent outbursts,
iv. bomb threats,
v. medical emergencies,
vi. chemical spills,
vii. situations involving a missing resident, and
viii. loss of one or more essential services. O. Reg. 79/10, s. 230 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the emergency plans provide for the following:
1. Dealing with s. 230(4), viii. loss of one or more essential services.

Review of intake #000080-18 revealed the home contacted the MOHLTC on an identified date, indicating a lack of heat in the home, and subsequently submitted CI #2967-000002-18 on an identified date. The CI indicated that the loss of heat was related to a failure/breakdown of the home's heating system due to a breakdown of the automatic controller that operated an identified care centre.

A review of the above mentioned CI indicated that on an identified date, the temperatures of the home had begun to drop due to the loss of heat and therefore, space heaters had been purchased for all identified resident rooms to maintain a temperature of 22 C, until a repair could be completed. A further review of the CI indicated that flow sheets had been developed and nursing and housekeeping monitored temperatures every half hour in each resident room.

Interview with the Manager of Nutrition and Environmental Services indicated that on an identified date, the home noticed a system failure with the heating system for half of the home. Between the onset of the failure on an identified date, the temperatures in the affected home areas had reduced to below the legislated requirement of 22 C. The home had responded by purchasing portables heaters for the affected resident rooms.

Staff were directed through a memo written by the Administrator, directing staff to check each resident room every half hour and record the temperature to ensure that 22 C was maintained.

A record review of the half hour temperature log sheet for for an identified date, several hours after the initiation of the portable heaters, indicated that 28 resident room temperatures remained below 22 C and continued to decrease. The above mentioned record review indicated that on an identified home area, resident room temperatures ranged from 14.7 C to 21.6 C, and on another identified home area, resident room temperatures ranged from 16.9 C to 21.9 C.

A further record review of the half hour temperature log sheet indicated that resident room temperatures were taken sporadically and not every half hour as directed. The records indicated that on the identified date, ten hours after the identified heat loss issue, room temperatures continued to decline. Room temperatures ranged from 14.7 C to 20.2 C, and one home area, and ranged from 14.7 C to 20.0 C in another home area.

When asked of Registered staff #104 and #105 if there were any further directions

provided as to how each room would be maintained at temperatures of 22 C with the current heating outage, the Registered staff indicated that they had only been directed to turn the space heater up from low to medium. The Registered staff further indicated that although they tried to increase the temperature in resident rooms, the heaters were shutting off because the heaters were breaking fuses. The Registered staff indicated that the Environmental Supervisor was called to the home, who assisted in repairing the fuses and moving the heaters to different outlets. The Registered staff further indicated that attempts were made to increase the temperature in each room, however confirmed that the rooms were not maintained at 22 C and continual monitoring of the rooms or residents in each room did not occur as there were no staff available to complete the extra duties.

An interview with the DOC confirmed that the loss of heat to the affected identified areas had a potential negative impact on residents. The DOC was asked whether the home had emergency plans for the loss of essential services that would have included, staff roles and responsibilities, communication plan to families, staff and residents, plan activation and lines of authority, availability of supplies, such as blankets, where the supplies are stored, how to monitor air temperatures, triage of residents based on risk, monitoring of hypothermia, and when would evacuation be warranted. DOC confirmed that the home did not have any emergency plans developed nor was it provided to the direct care staff for the loss of heating between the identified dates. .

A compliance order will be served to the home based on the scope, which is widespread as it involved more than one home area, and more than the fewest number of residents. The severity of the non-compliance has the potential to negatively affect the residents as the home had not developed a policy or written emergency plans that related to the loss of heat and essential service. There is no previous compliance history for this legislative reference. [s. 230. (4) 1. viii.]

Additional Required Actions:

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

Issued on this 31st day of January, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JENNIFER BROWN (647)
Inspection No. / No de l'inspection :	2018_491647_0001
Log No. / No de registre :	000080-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 31, 2018
Licensee / Titulaire de permis :	THE ONTARIO MISSION OF THE DEAF 2395 BAYVIEW AVENUE, NORTH YORK, ON, M2L-1A2
LTC Home / Foyer de SLD :	BOB RUMBALL HOME FOR THE DEAF 1 Royal Parkside Drive, BARRIE, ON, L4M-0C4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Shirley Cassel

To THE ONTARIO MISSION OF THE DEAF, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s.21. Specifically, the licensee must ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the home is maintained as a minimum temperature of 22 degrees Celsius (C).

Review of intake #000080-18 revealed the home contacted the Ministry of Health and Long Term Care (MOHLTC) on an identified date, indicating a lack of heat in the home, and subsequently submitted Critical Incident Report (CI) on an identified date. The CI indicated that the loss of heat was related to a failure/breakdown of the home's heating system due to a breakdown of the automatic controller that operated an identified care centre.

A review of the above mentioned CI indicated that on an identified date, the temperatures of the home had begun to drop, therefore, space heaters had been purchased for all identified resident rooms to maintain a temperature of 22 C, until a repair could be completed. A further review of the CI indicated that flow sheets had been developed and nursing monitored temperatures every half hour in each resident room.

A review of a memo written by the Administrator, directed staff to check each room every half hour and record the temperature to ensure that 22 C was maintained.

A record review of the half hour temperature log sheet was conducted. The

documented temperatures recorded for an identified date indicated that 21 out of the affected resident rooms remained less than the required temperature and ranged between 14.7-21.3 C.

On an identified date, the resident room temperatures had continued to not reach the required temperature of 22 C, and 28 out of the affected resident rooms continued to drop in temperature and ranged from 14.7-20.2C.

At no time between the first identified date and the second identified date, were any identified resident rooms maintained at 22 C, and had been confirmed during an interview with the Manager of Nutrition and Environmental Services and the Director of Care.

An interview with Registered staff #104 and #105, who had both worked during the affected period of time, indicated they were directed to take temperatures of each resident room every half hour and set the individual space heaters on low to maintain a temperature of 22 C. The identified staff further indicated that if the temperature was not maintained at the required temperature, Registered staff #104 and #105 had been directed to turn the heater up until the temperature would reach 22 C. The above mentioned staff indicated they did not have time to monitor each room every half hour as directed, and further indicated that when they did, the rooms had continued to be cold.

Interview with the Director of Care (DOC) indicated the above documented temperatures indicated above had been accurate and confirmed that the interventions of using space heaters had been ineffective in ensuring the home and all resident rooms on the affected care centres were maintained at a minimum temperature of 22 C and continued to decline. The DOC indicated the home had not been prepared for the breaker panel issue as a result of plugging 32 space heaters in to the electrical outlets.

A compliance order will be served to the home based on the scope, which is widespread as it involves more than one home area. More than a few residents were affected and the severity of the non-compliance had the potential to negatively affect residents as the temperatures on the affected home areas and had not been maintained as required. The home's monitoring plan also failed to implement measures to ensure that resident rooms were maintained at 22 C. There is no previous compliance history for this legislative reference. [s. 21.] (647)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 230. (4) The licensee shall ensure that the emergency plans provide for the following:
1. Dealing with,
i. fires,
ii. community disasters,
iii. violent outbursts,
iv. bomb threats,
v. medical emergencies,
vi. chemical spills,
vii. situations involving a missing resident, and
viii. loss of one or more essential services.
2. Evacuation of the home, including a system in the home to account for the whereabouts of all residents in the event that it is necessary to evacuate and relocate residents and evacuate staff and others in case of an emergency.
3. Resources, supplies and equipment vital for the emergency response being set aside and readily available at the home.
4. Identification of the community agencies, partner facilities and resources that will be involved in responding to the emergency. O. Reg. 79/10, s. 230 (4).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 230. Specifically, the licensee will prepare, submit and implement a plan to ensure that the home's emergency plans include how to deal with loss of heat in the home.

The plan will include, but is not limited to the following:
- A description of the staff training and education that will occur related to dealing with loss of heat in the home. Include who will be responsible for providing the education and the dates the training will occur.

The plan is to be submitted to jennifer.brown6@ontario.ca by February 16, 2018.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the emergency plans provide for the following: 1. Dealing with s. 230(4), viii. loss of one or more essential services.

Review of intake #000080-18 revealed the home contacted the MOHLTC on an identified date, indicating a lack of heat in the home, and subsequently submitted CI #2967-000002-18 on an identified date. The CI indicated that the loss of heat was related to a failure/breakdown of the home's heating system due to a breakdown of the automatic controller that operated an identified care centre.

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This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2018

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 Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, 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:

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS 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 de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et 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 31st day of January, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Jennifer Brown

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