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 # / Registre no	Type of Inspection / Genre d'inspection
Nov 30, 2016	2016_346133_0034	028241-16	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

BAY RIDGES
900 SANDY BEACH ROAD PICKERING ON L1W 1Z4

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 12th - 14th, 2016 (onsite)

The complaint inspection was related to a complaint regarding the home's roof.

During the course of the inspection, the inspector(s) spoke with the home's Executive Director, the home's Environmental Manager, one of the home's recreation assistants, a personal support worker, a plumber that provides plumbing services to the home, a heating, ventilation and air conditioning (HVAC) technician assigned to the home with the home's contracted HVAC company, a manager with the home's contracted HVAC company, a project manager with a general contracting company that provides services to the home, the Revera Regional Director of Operations for Long Term Care (ON East), a Revera Technical Specialist, a representative with the roofing and building envelope engineer company that provides services to the home, and a Revera project manager.

The Inspector reviewed maintenance service related documentation pertaining to: the heating, ventilation and air conditioning system, the roof (which includes the patio), plumbing in the area of the main lobby and the guest suite, and the sprinkler system. The Inspector conducted a walkabout inspection of resident bedrooms and common areas throughout the home with a focus on the condition of the ceilings. The Inspector observed the floor drain within the guest suite bathroom and the kitchen ceiling cavity below the guest suite. The Inspector observed a section of the ceiling cavity outside of the Dunsmore Park television lounge. The Inspector viewed videos taken of sections of the ceiling cavity within the Dunsmore Park television lounge.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 15 (2) (c) in that the licensee has failed to ensure that the home is maintained in safe condition and good state of repair. Despite processes in place that are meant to ensure the early identification of water leaks, two instances of water leaking were not known to the home's Environmental Manager and Executive Director prior to the Inspector's observations. This is specifically related to an area of water damaged drywall ceiling, above the stairway door outside of the Mitchel Park unit, as a result of condensation dripping from a pipe. This is also specifically related to water staining on the drywall ceiling within the Gathering room, as a result of water dripping from the vapor barrier within the ceiling space.

Related to the water damaged drywall ceiling, above the stairway door, outside of the Mitchel Park unit:

On Friday, October 14th, 2016, the Inspector observed that the ceiling above the stairway door, within the second floor lobby area, outside of the Mitchel Park unit, was in a poor state of repair. The affected ceiling area (the affected area) was approximately three to four feet in total length, along the edge of the ceiling, where the ceiling meets the wall (the seam), above the exit sign. On the far left of the affected area, the ceiling surface was raised (bubbled), approximately 20 centimeters (cm) out from the seam, approximately seven cm. in length, with no discoloration. To the right, there was a cracked area along the seam with small bubbles, pinholes, and black discoloration throughout. Approximately 15 cm. out from the seam, the surface was bubbled, the centre of the bubbled area was cracked, and there were three areas of black discoloration around the bubbled area. To the right, there was another area that was bubbled, cracked, and peeling, with light black discoloration around the perimeter. This

was approximately 15 cm. in length, along the seam, and approximately 10 cm. deep and 15 cm wide. On the far right of the affected area, the ceiling was stained light brown/light orange along the seam and approximately 45 cm. out from the seam in a semi-circular pattern. The seam was peeling. Within the centre of the stained area, there were two dark brown circular areas. The described areas of black discoloration were indicative of microbial growth.

The affected ceiling area, described above, was brought to the attention of the Executive Director (ED, #S101) and the Environmental Manager (EM, #S102). They indicated that they had not previously observed the water damaged drywall and areas of discoloration above the stairway door, nor had it been reported to them. It was also observed that there was a hole cut into the drywall ceiling, several feet out from the affected ceiling area above the stairway door, outside of the Mitchel Park unit. The hole in the ceiling exposed a leaking dry sprinkler system pipe. There was a bucket underneath the leaking pipe. The EM explained that the dry sprinkler system had been flushed, the week of September 26th, 2016, and a pinhole leak had been discovered in the pipe in this area. The EM pointed out that the pipe had been temporarily repaired with a clamp, although it appeared that the clamp may have become loosened. The EM explained that there was still some residual water in the pipe, following the flushing process. The EM advised that the home's fire safety contractor would be replacing the length of pipe, although the work had not yet been scheduled. The ED indicated that she believed that the quote to replace the pipe had been approved by the corporate office and that the EM could go ahead and schedule the work.

The EM informed the Inspector that there were contractors from a general contracting company coming into the home on Monday, October 17th, 2016 to do some planned ceiling repairs, originally quoted on September 8th, 2016. The planned work included repairs to the ceiling within the Mitchel Park unit and the first floor lobby. The planned work to the ceiling within the Mitchel Park unit was related to the sprinkler system and the heating, ventilation and air conditioning (HVAC) system. Related to the sprinkler system, on August 24th, 2016, there had been an air leak in the dry sprinkler system, and a length of pipe had to be replaced, in the area of the Mitchel Park nurses' station. The drywall ceiling had to be cut open to allow for ceiling access to plumbers. Related to the HVAC system, on July 14th 2016, there had been water damage to the drywall ceiling and bulkhead within the Mitchel Park sunroom, caused by a drainage issue in one of the roof top air conditioning units. The drainage issue was rectified on July 15th, 2016, after the roof was ruled out as the cause of the leak. The planned repair work to the ceiling in the first floor lobby was related to a leaking hot water pipe, which had damaged the

drywall ceiling, and which had been repaired on June 8th, 2016 and then again on August 4th, 2016. The EM anticipated that the contractors that were coming in on October 17th, 2016, could also address the affected ceiling area, above the stairway door, outside of the Mitchel Park unit.

On October 17th, 2016, at approximately 11:40 hours, the Inspector spoke with a project manager with the general contracting company (PM, #S103) on the telephone. The PM confirmed that she would personally observe and assess the affected ceiling area outside of the Mitchel Park unit, above the stairway door, in order to determine what follow up action was required. The PM confirmed that her company had a background in microbial growth abatement.

On Monday, October 17th, 2016, the Inspector spoke with the home's ED on the telephone. The ED informed that the contractors had cut out the affected ceiling area, and that the open area was now sealed with plastic. She advised that the source of the damage was dripping water from a pipe within the ceiling cavity, connected to a rooftop air conditioning unit. The ED advised that the pipe needed to be re-insulated. Following that, the contractors would return for further investigation into the wall below the affected ceiling area. She provided the Inspector with pictures of the ceiling area once it was opened, of the pipe in question, and of the ceiling area once it was sealed. The picture of the insulated pipe showed an exposed area of pipe and to the right of that, a wet area on the insulation that spanned from top to bottom. The ED confirmed that the air conditioning unit was no longer in use, and therefore no longer dripping.

On Friday, October 21st, 2016, the Inspector spoke with the project manager with the general contracting company (PM, #S103)on the telephone. She explained that on Monday October 17th, 2016, based on her observation and assessment of the affected ceiling area above the stairway door, outside of the Mitchel Park unit, the contractors cut away beyond the perimeter of the affected area. The contractors then used a HEPA filtered vacuum to clean the space, wiped it all down, covered the area with six millimeter plastic and sealed the perimeter with tuck tape so that it was airtight. The PM, #S103, advised that once the pipe was re-insulated, she would arrange for contractors to return to the home and make small test cuts into the wall, to verify if there was any evidence of water damage. She explained that the actions taken by the contractors were dictated by the fact that the affected area was less than ten square feet.

On Monday, October 24th, 2016, the Inspector spoke with the home's assigned heating, ventilation and air conditioning (HVAC) technician (#S104) about the dripping pipe. He

explained that he had been in the home on Monday the 17th, 2016, conducting maintenance on HVAC equipment, and that he had been asked to take a look at the pipe once the affected ceiling area was cut out. He explained that as per his observations, the seams of the pipe's insulation were not sealed, and that there was also a tear, that approximately a one inch piece of insulation was missing on the top of one of the lengths of insulation. He explained that this was an installation issue. He explained that as a result of the exposed pipe areas, there would have been a lot of condensation generated. He explained that the insulation is meant to retain moisture, but due to the tear and the unsealed seams, the excessive moisture could not have been contained.

On Tuesday, October 25th, 2016, the home's ED advised the Inspector that a quote had been obtained for the re-insulation of the pipe. On Tuesday, November 15th, 2016, the home's ED and the Revera Regional Director of Operations for Long Term Care (ON East) (RD #S109) informed the Inspector that that pipe had been re-insulated. The ED and the RD informed the Inspector that the contractors would be back in to the home on Wednesday, November 16th, 2016. They informed that the contractors would make a test cut into the wall beneath the affected ceiling area to determine if there had been any water damage. Follow up actions would be dictated by what the contractors observed and the process would be documented by a representative of the general contractors company.

Related to the water stained drywall ceiling within the Gathering room:

On Thursday, October 13th, 2016, the Inspector observed that the ceiling in the main floor Gathering Room was in a poor state of repair. There was a light brown circular stain around the fire alarm horn and a second light brown circular stain in the immediate area of the fire alarm horn. There was a crack along the drywall tape seam. The area appeared to be dry.

The affected ceiling area, described above, was brought to the attention of the Environmental Manager (EM, #S102). The EM indicated that he had not previously observed this affected area, nor had it been reported to him. The EM speculated that this staining was related to the patio, which is centrally located above the Gathering Room. The EM informed that there was a patio remediation project in the works. It was ascertained over the course of the onsite inspection that in the past, there had been water infiltration into the Welcome room and into the main lobby entrance vestibule, related to the North and South patio door thresholds respectively. As well, it was ascertained that following corrective actions related to the patio door thresholds, there

was another occurrence of water infiltration into the main lobby entrance vestibule, believed to also be related to the patio above. At the time of the onsite inspection, there was an identified area on the South side of the patio, above the entrance vestibule, where there was indication of rot damage ("soft" area). As per a site review document from the home's contracted roofing and building envelope engineer company, dated June 23, 2016, the wall behind the "soft" area was identified to be in poor condition. Factors were described that allowed for "water to be diverted into the interior and balcony system". On Thursday, October 13th, 2016, in the company of the home's ED, the Inspector spoke with a Revera technical specialist (#S110) and a representative of the roofing and building envelope engineer company (#S111) about the scope of work required for the patio and wall remediation project. The Inspector was informed that a bidding process for the project had been completed. The ED was informed by the Revera technical specialist that the project was approved and that she could go ahead with operational planning.

On Wednesday, October 19th, 2016, the home's EM and the Inspector spoke on the phone and the EM informed that he had looked up into the Gathering room ceiling cavity, through a pot light hole. He informed that he had observed a water stain around a screw and nothing more. He informed that there was nothing leaking. He informed that there had been heavy rain the night before. He indicated that he would follow the area.

On Friday, October 21st, 2016, the home's EM and the Inspector spoke on the phone and the EM informed that he had again looked up into the Gathering room ceiling cavity through the pot light hole. He explained that there had been a lot of rain since October 19th, 2016, when he first observed the ceiling cavity. The EM informed that he was now seeing some water leaking from the area above the stained drywall ceiling. The EM informed that the roofing and building envelope engineer company had been called in to observe the water infiltration. The EM informed that the roofing and building envelope engineer company would produce a report that would speak to the possible cause and detail necessary corrective actions.

Upon request from the Inspector, the EM took a picture of the ceiling cavity and emailed it to the Inspector. The picture showed a wet area on a piece of drywall within the ceiling cavity. The picture showed light staining, from the wet area to the edge of the drywall, and darker staining, along the edge of the drywall. Above the drywall there was vapor barrier.

On Tuesday, October 25th, 2016, the Inspector spoke with the home's ED and the

Revera Regional Director of Operations for Long Term Care (ON East) (RD #S109) about the Operational Plan submitted by the home to the Ministry which detailed the patio and wall remediation project. The Regional Director indicated that should the ceiling staining in the Gathering Room and the water damaged building materials within the ceiling cavity above the stained area be related to the patio, they would address it during the patio and wall remediation project. It was anticipated that the project would begin November 8th or 15th, dependent on Ministry approval and weather permitting.

On Monday, October 31st, 2016, the home's ED provided the Inspector with a report, dated October 21st, 2016, from the roofing and building envelope engineer company, related to the roof leak (roof serves as the patio) affecting the Gathering Room ceiling. The author noted that water had been observed "dripping from a seam in the polyethylene vapor barrier". The author noted that "an area of the drywall ceiling, immediately beside the pot light, was wet however the water had not yet penetrated the drywall". The author also noted that "no black staining was observed on the ceiling or within the ceiling space". The author could only speculate as to the cause of the dripping water and recommended further investigation and testing, to be done in conjunction with the scheduled building envelope repairs (a.k.a the patio project).

On Monday November 7th, 2016, the ED confirmed that the patio project would be starting on November 8th, 2016 and that the investigation and testing recommended by the roofing and building envelope engineer company, related to the Gathering Room ceiling, would be done in conjunction with the project.

On Tuesday, November 8th, 2016, the ED emailed the Inspector a document that contained an overview of processes in place that are meant to provide for the early identification of water leaks and infiltration. On Tuesday, November 15th, 2016, the Inspector spoke with the home's ED and the Revera Regional Director of Operations for Long Term Care (ON East) (RD, #S109) about the information provided. The RD explained that scheduled inspections and preventative maintenance of major systems or equipment that incorporate water, such as the HVAC system, the sprinkler system and the roof, are one way in which the home ensures early identification of water leaks/infiltration. The Inspector was informed that a third party contractor, who supports the dietary and environmental programs at the home, conducts a semi-annual inspection of the entire building. The semi-annual inspections include ceilings in all common areas. The Inspector was informed that all staff in the home are aware of the need to report maintenance issues and are educated how to do so, including the reporting of any evidence of water leaking/infiltration. The Inspector was informed that registered nursing

staff complete a 24-hour report on which environmental issues within their designated care unit are to be documented. The Inspector was informed that every day, the management team does a walkabout inspection of the home, known as a MBWA, or management by walkabout, which includes observation of the ceiling in common areas such as dining rooms, sunrooms, dens and hallways. The ED explained that each manager is assigned a specific resident home area. The ED explained that she does all areas of both floors every day. The ED explained that the Director of Care and the Assistant Director of Care each do one floor. The ED explained that the Environmental Manager does all common areas of the home and a selection of resident bedrooms every day. The ED confirmed that as a result of the MBWA process, there should be three to four senior managers observing the ceiling in common areas such as hallways and the Gathering Room every day. The ED confirmed that the damaged and discolored ceiling area above the stairway door outside of the Mitchel Park unit had not been picked up by the MBWA process. The ED confirmed that the stained ceiling in the Gathering Room had not been picked up by the MBWA process.

The licensee has a history of non-compliance with LTCHA, 2007, s. 15 (2) (c). As a result of the 2015 Resident Quality Inspection (#2015_195166_0007), conducted in April 2015, a written notification was issued with the additional required action of a voluntary plan of correction. The scope of the non-compliance described in this report is widespread as it pertains to two common areas of the home. The non-compliance presents a potential for risk to residents, as water damaged building materials may support microbial growth. In light of these three factors, a compliance order will be served to the licensee. [s. 15. (2) (c)]

Additional Required Actions:

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

Issued on this 5th day of December, 2016

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA LAPENSEE (133)
Inspection No. / No de l'inspection :	2016_346133_0034
Log No. / Registre no:	028241-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 30, 2016
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	BAY RIDGES 900 SANDY BEACH ROAD, PICKERING, ON, L1W-1Z4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Andrea DeLuca

To REVERA LONG TERM CARE INC., 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 :

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,

(a) the home, furnishings and equipment are kept clean and sanitary;

(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and

(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

In order to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 15 (2) (c), the licensee shall develop and implement a systematic preventative maintenance procedure that will ensure that any indications of water infiltration or leaking are detected immediately, assessed and rectified without delay, in order to prevent or mitigate microbial growth and to ensure residents safety. The procedure shall include the processes that will be followed should there be any visual evidence of microbial growth as a result of the infiltration or leaking. The procedure shall be detailed in writing.

Specifically related to the water damaged ceiling area above the stairway door before the entrance to the Mitchell Park unit (#1), the licensee will ensure that the wall beneath the area is subject to further invasive investigation, by an organization with experience in microbial growth abatement, in order to determine if there has been water damage. The licensee shall ensure that a document is produced, by the organization that does the work, that describes the invasive investigation and the results.

Specifically related to the stained ceiling area in the Gathering room and the water damaged building materials in the ceiling cavity above the area (#2), the licensee will ensure that the cause of the water infiltration is assessed and rectified without delay. The licensee will ensure that a document is produced, by the organizations(s) that do the work, that outlines the cause of the water infiltration and details the corrective actions taken. The licensee will ensure that the water damaged building material within the ceiling cavity is assessed for the possibility of microbial growth, by an organization with experience in such assessment. This assessment shall be documented.

Should evidence be found of microbial growth in either case (#1 and #2), abatement shall be done in accordance with evidence-based practices, by an organization with experience in abatement. The licensee shall ensure that a document is produced, by the organization that does the abatement, which describes the abatement procedure and references the evidence based practice (s) that guided the work.

Grounds / Motifs :

1. 1. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 15 (2) (c) in that the licensee has failed to ensure that the home is maintained in safe condition and good state of repair. Despite processes in place that are meant to ensure the early identification of water leaks, two instances of water

leaking were not known to the home's Environmental Manager and Executive Director prior to the Inspector's observations. This is specifically related to an area of water damaged drywall ceiling, above the stairway door outside of the Mitchel Park unit, as a result of condensation dripping from a pipe. This is also specifically related to water staining on the drywall ceiling within the Gathering room, as a result of water dripping from the vapor barrier within the ceiling space.

Related to the water damaged drywall ceiling, above the stairway door, outside of the Mitchel Park unit:

On Friday, October 14th, 2016, the Inspector observed that the ceiling above the stairway door, within the second floor lobby area, outside of the Mitchel Park unit, was in a poor state of repair. The affected ceiling area (the affected area) was approximately three to four feet in total length, along the edge of the ceiling, where the ceiling meets the wall (the seam), above the exit sign. On the far left of the affected area, the ceiling surface was raised (bubbled), approximately 20 centimeters (cm) out from the seam, approximately seven cm. in length, with no discoloration. To the right, there was a cracked area along the seam with small bubbles, pinholes, and black discoloration throughout. Approximately 15 cm. out from the seam, the surface was bubbled, the centre of the bubbled area was cracked, and there were three areas of black discoloration around the bubbled area. To the right, there was another area that was bubbled, cracked, and peeling, with light black discoloration around the perimeter. This was approximately 15 cm. in length, along the seam, and approximately 10 cm. deep and 15 cm wide. On the far right of the affected area, the ceiling was stained light brown/light orange along the seam and approximately 45 cm. out from the seam in a semi-circular pattern. The seam was peeling. Within the centre of the stained area, there were two dark brown circular areas. The described areas of black discoloration were indicative of microbial growth.

The affected ceiling area, described above, was brought to the attention of the Executive Director (ED, #S101) and the Environmental Manager (EM, #S102). They indicated that they had not previously observed the water damaged drywall and areas of discoloration above the stairway door, nor had it been reported to them. It was also observed that there was a hole cut into the drywall ceiling, several feet out from the affected ceiling area above the stairway door, outside of the Mitchel Park unit. The hole in the ceiling exposed a leaking dry sprinkler system pipe. There was a bucket underneath the leaking pipe. The EM

explained that the dry sprinkler system had been flushed, the week of September 26th, 2016, and a pinhole leak had been discovered in the pipe in this area. The EM pointed out that the pipe had been temporarily repaired with a clamp, although it appeared that the clamp may have become loosened. The EM explained that there was still some residual water in the pipe, following the flushing process. The EM advised that the home's fire safety contractor would be replacing the length of pipe, although the work had not yet been scheduled. The ED indicated that she believed that the quote to replace the pipe had been approved by the corporate office and that the EM could go ahead and schedule the work.

The EM informed the Inspector that there were contractors from a general contracting company coming into the home on Monday, October 17th, 2016 to do some planned ceiling repairs, originally quoted on September 8th, 2016. The planned work included repairs to the ceiling within the Mitchel Park unit and the first floor lobby. The planned work to the ceiling within the Mitchel Park unit was related to the sprinkler system and the heating, ventilation and air conditioning (HVAC) system. Related to the sprinkler system, on August 24th, 2016, there had been an air leak in the dry sprinkler system, and a length of pipe had to be replaced, in the area of the Mitchel Park nurses' station. The drywall ceiling had to be cut open to allow for ceiling access to plumbers. Related to the HVAC system, on July 14th 2016, there had been water damage to the drywall ceiling and bulkhead within the Mitchel Park sunroom, caused by a drainage issue in one of the roof top air conditioning units. The drainage issue was rectified on July 15th, 2016, after the roof was ruled out as the cause of the leak. The planned repair work to the ceiling in the first floor lobby was related to a leaking hot water pipe, which had damaged the drywall ceiling, and which had been repaired on June 8th, 2016 and then again on August 4th, 2016. The EM anticipated that the contractors that were coming in on October 17th, 2016, could also address the affected ceiling area, above the stairway door, outside of the Mitchel Park unit.

On October 17th, 2016, at approximately 11:40 hours, the Inspector spoke with a project manager with the general contracting company (PM, #S103) on the telephone. The PM confirmed that she would personally observe and assess the affected ceiling area outside of the Mitchel Park unit, above the stairway door, in order to determine what follow up action was required. The PM confirmed that her company had a background in microbial growth abatement.

On Monday, October 17th, 2016, the Inspector spoke with the home's ED on the telephone. The ED informed that the contractors had cut out the affected ceiling area, and that the open area was now sealed with plastic. She advised that the source of the damage was dripping water from a pipe within the ceiling cavity, connected to a rooftop air conditioning unit. The ED advised that the pipe needed to be re-insulated. Following that, the contractors would return for further investigation into the wall below the affected ceiling area. She provided the Inspector with pictures of the ceiling area once it was opened, of the pipe in question, and of the ceiling area once it was sealed. The picture of the insulated pipe showed an exposed area of pipe and to the right of that, a wet area on the insulation that spanned from top to bottom. The ED confirmed that the air conditioning unit was no longer in use, and therefore no longer dripping.

On Friday, October 21st, 2016, the Inspector spoke with the project manager with the general contracting company (PM, #S103)on the telephone. She explained that on Monday October 17th, 2016, based on her observation and assessment of the affected ceiling area above the stairway door, outside of the Mitchel Park unit, the contractors cut away beyond the perimeter of the affected area. The contractors then used a HEPA filtered vacuum to clean the space, wiped it all down, covered the area with six millimeter plastic and sealed the perimeter with tuck tape so that it was airtight. The PM, #S103, advised that once the pipe was re-insulated, she would arrange for contractors to return to the home and make small test cuts into the wall, to verify if there was any evidence of water damage. She explained that the actions taken by the contractors were dictated by the fact that the affected area was less than ten square feet.

On Monday, October 24th, 2016, the Inspector spoke with the home's assigned heating, ventilation and air conditioning (HVAC) technician (#S104) about the dripping pipe. He explained that he had been in the home on Monday the 17th, 2016, conducting maintenance on HVAC equipment, and that he had been asked to take a look at the pipe once the affected ceiling area was cut out. He explained that as per his observations, the seams of the pipe's insulation were not sealed, and that there was also a tear, that approximately a one inch piece of insulation was missing on the top of one of the lengths of insulation. He explained that this was an installation issue. He explained that as a result of the exposed pipe areas, there would have been a lot of condensation generated. He explained that the insulation is meant to retain moisture, but due to the tear and the unsealed seams, the excessive moisture could not have been contained.

On Tuesday, October 25th, 2016, the home's ED advised the Inspector that a quote had been obtained for the re-insulation of the pipe. On Tuesday, November 15th, 2016, the home's ED and the Revera Regional Director of Operations for Long Term Care (ON East) (RD #S109) informed the Inspector that that pipe had been re-insulated. The ED and the RD informed the Inspector that the contractors would be back in to the home on Wednesday, November 16th, 2016. They informed that the contractors would make a test cut into the wall beneath the affected ceiling area to determine if there had been any water damage. Follow up actions would be dictated by what the contractors observed and the process would be documented by a representative of the general contractors company.

Related to the water stained drywall ceiling within the Gathering room:

On Thursday, October 13th, 2016, the Inspector observed that the ceiling in the main floor Gathering Room was in a poor state of repair. There was a light brown circular stain around the fire alarm horn and a second light brown circular stain in the immediate area of the fire alarm horn. There was a crack along the drywall tape seam. The area appeared to be dry.

The affected ceiling area, described above, was brought to the attention of the Environmental Manager (EM, #S102). The EM indicated that he had not previously observed this affected area, nor had it been reported to him. The EM speculated that this staining was related to the patio, which is centrally located above the Gathering Room. The EM informed that there was a patio remediation project in the works. It was ascertained over the course of the onsite inspection that in the past, there had been water infiltration into the Welcome room and into the main lobby entrance vestibule, related to the North and South patio door thresholds respectively. As well, it was ascertained that following corrective actions related to the patio door thresholds, there was another occurrence of water infiltration into the main lobby entrance vestibule, believed to also be related to the patio above. At the time of the onsite inspection, there was an identified area on the South side of the patio, above the entrance vestibule, where there was indication of rot damage ("soft" area). As per a site review document from the home's contracted roofing and building envelope engineer company, dated June 23, 2016, the wall behind the "soft" area was identified to be in poor condition. Factors were described that allowed for "water to be diverted into the interior and balcony system". On Thursday,

October 13th, 2016, in the company of the home's ED, the Inspector spoke with a Revera technical specialist (#S110) and a representative of the roofing and building envelope engineer company (#S111) about the scope of work required for the patio and wall remediation project. The Inspector was informed that a bidding process for the project had been completed. The ED was informed by the Revera technical specialist that the project was approved and that she could go ahead with operational planning.

On Wednesday, October 19th, 2016, the home's EM and the Inspector spoke on the phone and the EM informed that he had looked up into the Gathering room ceiling cavity, through a pot light hole. He informed that he had observed a water stain around a screw and nothing more. He informed that there was nothing leaking. He informed that there had been heavy rain the night before. He indicated that he would follow the area.

On Friday, October 21st, 2016, the home's EM and the Inspector spoke on the phone and the EM informed that he had again looked up into the Gathering room ceiling cavity through the pot light hole. He explained that there had been a lot of rain since October 19th, 2016, when he first observed the ceiling cavity. The EM informed that he was now seeing some water leaking from the area above the stained drywall ceiling. The EM informed that the roofing and building envelope engineer company had been called in to observe the water infiltration. The EM informed that the roofing and building envelope engineer company would produce a report that would speak to the possible cause and detail necessary corrective actions.

Upon request from the Inspector, the EM took a picture of the ceiling cavity and emailed it to the Inspector. The picture showed a wet area on a piece of drywall within the ceiling cavity. The picture showed light staining, from the wet area to the edge of the drywall, and darker staining, along the edge of the drywall. Above the drywall there was vapor barrier.

On Tuesday, October 25th, 2016, the Inspector spoke with the home's ED and the Revera Regional Director of Operations for Long Term Care (ON East) (RD #S109) about the Operational Plan submitted by the home to the Ministry which detailed the patio and wall remediation project. The Regional Director indicated that should the ceiling staining in the Gathering Room and the water damaged building materials within the ceiling cavity above the stained area be related to the patio, they would address it during the patio and wall remediation project. It

was anticipated that the project would begin November 8th or 15th, dependent on Ministry approval and weather permitting.

On Monday, October 31st, 2016, the home's ED provided the Inspector with a report, dated October 21st, 2016, from the roofing and building envelope engineer company, related to the roof leak (roof serves as the patio) affecting the Gathering Room ceiling. The author noted that water had been observed "dripping from a seam in the polyethylene vapor barrier". The author noted that "an area of the drywall ceiling, immediately beside the pot light, was wet however the water had not yet penetrated the drywall". The author also noted that "no black staining was observed on the ceiling or within the ceiling space". The author could only speculate as to the cause of the dripping water and recommended further investigation and testing, to be done in conjunction with the scheduled building envelope repairs (a.k.a the patio project).

On Monday November 7th, 2016, the ED confirmed that the patio project would be starting on November 8th, 2016 and that the investigation and testing recommended by the roofing and building envelope engineer company, related to the Gathering Room ceiling, would be done in conjunction with the project.

On Tuesday, November 8th, 2016, the ED emailed the Inspector a document that contained an overview of processes in place that are meant to provide for the early identification of water leaks and infiltration. On Tuesday, November 15th, 2016, the Inspector spoke with the home's ED and the Revera Regional Director of Operations for Long Term Care (ON East) (RD, #S109) about the information provided. The RD explained that scheduled inspections and preventative maintenance of major systems or equipment that incorporate water, such as the HVAC system, the sprinkler system and the roof, are one way in which the home ensures early identification of water leaks/infiltration. The Inspector was informed that a third party contractor, who supports the dietary and environmental programs at the home, conducts a semi-annual inspection of the entire building. The semi-annual inspections include ceilings in all common areas. The Inspector was informed that all staff in the home are aware of the need to report maintenance issues and are educated how to do so, including the reporting of any evidence of water leaking/infiltration. The Inspector was informed that registered nursing staff complete a 24-hour report on which environmental issues within their designated care unit are to be documented. The Inspector was informed that every day, the management team does a walkabout inspection of the home, known as a MBWA, or management by

walkabout, which includes observation of the ceiling in common areas such as dining rooms, sunrooms, dens and hallways. The ED explained that each manager is assigned a specific resident home area. The ED explained that she does all areas of both floors every day. The ED explained that the Director of Care and the Assistant Director of Care each do one floor. The ED explained that the Environmental Manager does all common areas of the home and a selection of resident bedrooms every day. The ED confirmed that as a result of the MBWA process, there should be three to four senior managers observing the ceiling in common areas such as hallways and the Gathering Room every day. The ED confirmed that the damaged and discolored ceiling area above the stairway door outside of the Mitchel Park unit had not been picked up by the MBWA process. The ED confirmed that the stained ceiling in the Gathering Room had not been picked up by the MBWA process.

The licensee has a history of non-compliance with LTCHA, 2007, s. 15 (2) (c). As a result of the 2015 Resident Quality Inspection (#2015_195166_0007), conducted in April 2015, a written notification was issued with the additional required action of a voluntary plan of correction. The scope of the non-compliance described in this report is widespread as it pertains to two common areas of the home. The non-compliance presents a potential for risk to residents, as water damaged building materials may support microbial growth. In light of these three factors, a compliance order will be served to the licensee. [s. 15. (2) (c)] (133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 09, 2017

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 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 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 30th day of November, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JESSICA LAPENSEE

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