Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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

Original Public Report

Report Issue Date: June 23, 2023

Inspection Number: 2023-1368-0002

Inspection Type:
Complaint

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Rouge Valley, Toronto

Lead Inspector	**Inspector Digital Signature**
Julie Dunn (706026)	Julie Dunn Digitally signed by Julie Dunn Date: 2023.06.29 15:44:34 -04'00'

Additional Inspector(s)
Laura Crocker (741753)

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 7, 8, 9, and 12, 2023, with June 7, 8 and 12 occurring onsite and June 9, 2023 occurring offsite.

The following intake(s) were inspected:
· Intake: #00089535 - Complaint regarding concerns with no air conditioning.

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

Safe and Secure Home
Infection Prevention and Control

INSPECTION RESULTS

COMPLIANCE ORDER CO #001 COOLING REQUIREMENTS

NC #001 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 23 (4) (b)

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

The licensee shall:

1. Provide education to the registered staff, the Personal Support Workers (PSWs), the Maintenance Supervisor, the Assistant Directors of Care (ADOCs), the Director of Care (DOC) and the Administrator on the home's Preventing Heat-Related Illnesses Policy.
2. Develop and implement a communication system to alert the interdisciplinary team, including the Charge Nurse, Maintenance Supervisor, Registered staff, and the home's management team when air temperatures in the home reach 26 degrees Celsius or above. Keep a documented record of the communication alert system developed, how it was implemented, and a list of those staff educated on the implemented communication alert system and staff's roles and responsibilities.
3. Develop and implement a daily audit sheet with the ADOC or designate to ensure the home's Preventing Heat-Related Illnesses Policy is being followed by registered staff. Keep a documented record of the resident name, room numbers, date, and time the room was out of range, and the date and time the audit was completed. If the Preventing Heat-Related Illnesses Policy was not followed, the ADOC or designate will re-train the staff member(s). Keep a documented record of the date, the name of the ADOC or designate who provided the staff education, the name of the staff who received the education and what education was provided.

Grounds
The licensee has failed to ensure the heat related illness prevention and management plan for the home was implemented when the temperature in an area of the home measured by the licensee in accordance with subsections 24 (2) and (3) reached 26 degrees Celsius or above, for the remainder of the day and the following day.

Rationale and Summary
A complaint was received by the Director alleging a longstanding concern of air conditioning in disrepair in the long-term care (LTC) home.

The home's Preventing Heat-Related Illnesses Policy indicated a communication system was developed to alert care staff when the home's heat-related illness prevention and management plan for the home was to be implemented, at minimum: 26 degrees Celsius or above, for the remainder of the day; and anytime the measured temperature in an area in the home reached 26 degrees Celsius or above on the previous day. The policy also stated the Charge Nurse will take the residents' temperature as part of the clinical assessment during hot weather as clinically indicated. Document in the progress notes the resident's condition, status, assessment, and response to treatment whenever there is a significant change in condition or new strategy implemented. Complete relevant referrals, consult with the interdisciplinary team to develop a plan of care. Ensure there is one or more designated area(s) where residents may go to seek refuge from the heat, as required, and that this has been communicated to all care staff. The designated area must be large enough to prevent overcrowding and well ventilated.

Review of the homes air temperature logs for a three-week time period indicated air temperatures in some home areas and resident rooms were 26 degrees Celsius or above for consecutive hours and days.

Review of the air temperature reports indicated the home's air temperatures were recorded every hour in certain resident rooms and home areas and highlighted when the air temperature was 26.5 degrees Celsius or above. In an interview, the Maintenance Supervisor reported that when a resident's room or home area was 26.5 degrees Celsius or above, an alert was received on their phone, and the same alert also went to the Charge Nurse's phone. The Maintenance Supervisor agreed the alerts were not communicated via the phone for air temperatures measuring 26 degrees Celsius or above. The Maintenance Supervisor further reported that phone alerts only went out once, when the air temperature was initially detected at 26.5 degrees Celsius, therefore no phone alerts were communicated when resident rooms and home areas remained above 26.5 degrees Celsius for consecutive hours and days.

Two Registered Nurses (RNs) reported the communication system developed to alert care staff when the home's heat-related illness prevention and management plan was implemented included phone alerts, documenting in the resident progress notes out of range air temperatures, resident assessments, and interventions for the heat related illness prevention and management plan. The RNs also indicated they communicated the implemented interventions, and out of range air temperatures by documenting in the RN daily report book.

An RN showed inspector #706026 the RN daily report book where out of range home air temperatures and implemented resident interventions would be documented. The RN and inspector reviewed the handwritten notes documented in the RN daily report book for each shift during a

specific time period when air temperatures were recorded as 26 degrees Celsius or above in resident rooms and common areas. The RN confirmed there were no notes related to air temperatures or room temperatures in the book during this time period; furthermore, there were no notes related to interventions to be implemented related to air temperatures outside of the acceptable range. The RN also showed inspector #706026 the mobile phone that alerted the Charge Nurse when temperatures went out of range. Two RNs reported they did not carry the mobile phone with them to receive alerts. The phone stayed in the Charge Nurse's office and was checked throughout the day.

Review of four residents' progress notes showed no nursing assessment of the air temperatures in the residents' rooms, no resident assessments, and no notes indicating the heat related illness prevention and management plan was implemented when air temperatures were logged above the acceptable range in the above residents' rooms from during the specific time period. An RN reported they were not aware of the out-of-range room temperatures on a specific date for two residents as they had not received an alert on the phone, nor was it communicated by staff indicating the air temperature was 26 degrees Celsius or above, therefore no heat related illness plan was implemented for either resident. The air temperature records provided by the LTC home indicated that on a specific date, the air temperature in a resident's room ranged from 26 to 27.5 degrees Celsius and the air temperature in a second resident's room ranged from 26.5 to 28 degrees Celsius.

Heat risk assessments for two residents indicated they were high risk for heat related illnesses. Review of the residents' temperature logs in Point Click Care (PCC) indicated the residents' temperatures were not taken as part of the heat related illness prevention and management plan when the resident's room temperature was recorded as above 26 degrees Celsius. Review of two residents' recorded body temperature in PCC also indicated no recorded resident temperatures when their rooms were logged above the acceptable range. An RN confirmed it was clinically appropriate for the residents' body temperatures to be taken and recorded in PCC when their rooms' air temperatures were reading high for numerous hours and days.

Two RNs indicated when the resident rooms or home area temperatures were alerted as above 26 degrees Celsius, they involved the interdisciplinary team, by communicating with the Registered Practical Nurses (RPNs) on the unit, calling the Maintenance Supervisor, DOC and ADOCs. The Maintenance Supervisor reported when they received an alert via the phone or received a call from the Nurse about a high temperature in a home area or resident room, they would implement interventions including, opening windows, taking fans to home areas, close blinds, or alert staff to move residents to other areas, as well the vendor would be called to fix the deficiencies. The Administrator reported the DOC would be made aware of any resident heat related issues. The DOC

reported they were involved with the clinical aspect related to the heat related illness prevention and management plan, however when the DOC reviewed the temperature report logs for the three-week time period, the DOC acknowledged they were not aware of the high temperatures in these areas. Two RNs, the DOC, the Administrator, and the Maintenance Supervisor did not provide documentation to support what specific interventions and what plan of care was developed to bring down air temperatures in resident rooms and home areas when air temperatures went above the acceptable range, 26 degrees Celsius or above.

An RN indicated cooling areas in the home included the dining room and activity room. An RPN reported there were no designated cooling areas in the home as the home was fully air conditioned and a second RPN reported the designated cooling areas included the hallway and the resident's room by the air conditioning vent. Both RPNs reported they were not aware of any air conditioning deficiencies in the home; however, an RN reported the air conditioning deficiencies in the home had been going on for years. The DOC and Maintenance Supervisor reported the designated cooling areas included the lounge, dining room and hallway by the ceiling mounted air conditioning units but agreed only two or three residents could be in that area at one time. Review of the temperature logs indicated the areas staff reported as cooling areas were at times logged in the air temperature report as 26 degrees Celsius or above. The Maintenance Supervisor acknowledged that the areas designated as cooling areas including the lounge, activity room, and dining room had been impacted by the air-conditioning deficiencies and therefore at times were at 26 degrees Celsius or above.

Failure to ensure the heat related illness prevention and management plan was implemented when the air temperature was 26 degrees Celsius or above in resident rooms and cooling areas increased the residents' risk for heat related illness.

Sources: The home's Preventing Heat-Related Illnesses Policy, Air Temperature Records, interviews with staff.

[741753]

This order must be complied with by July 27, 2023.

COMPLIANCE ORDER CO #002 AIR CONDITIONING REQUIREMENTS

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 23.1 (3) 1.

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

The licensee shall:

1. Engage a Heating Ventilation and Air Conditioning (HVAC) Engineer/Technician to execute the repairs and services to ensure air conditioning is operating efficiently for the purpose of cooling the temperature in every resident room.
2. Monitor and record air temperatures in each resident's room once a day in the afternoon between 12 p.m. and 5 p.m. to ensure cooling is at a comfortable level for residents. The temperature logs must be filed, maintained in the home, and emailed daily to: centraleastdistrict.mltc@ontario.ca
3. Review air temperature records daily and document action(s) taken for all temperatures at 26 degrees Celsius or above. Provide documentation of actions taken at request of inspector. Continue monitoring until air temperatures are consistently maintained at a comfortable level for residents, at a minimum of 22 degrees Celsius and below 26 degrees Celsius. Continue to monitor and record air temperatures in residents' rooms for one month after compliance is achieved with this order.
4. Provide re-education for the Maintenance Supervisor and registered staff related to actions taken when air temperatures are at 26 degrees Celsius or above in the home and maintain a documented record of the education provided.

Grounds

The licensee failed to ensure air conditioning was operating in every resident bedroom of the long-term care home when needed to maintain the temperature at a comfortable level for residents, when the temperature in areas of the home measured by the licensee reached 26 degrees Celsius or above.

A complaint was received by the Director alleging a longstanding concern of air conditioning in disrepair in the long-term care (LTC) home.

Summary and Rationale:

Environment and Climate Change Canada reported the maximum temperature in Toronto was above 30 degrees Celsius on two consecutive days.

In an interview, an RN indicated that the air conditioning was not working in some parts of the building, and that there were always ongoing issues with the air conditioning for at least four years. The RN stated there was concern with the air temperatures, and the windows were not to be opened, as there was hot weather and concern with air quality.

In interviews with two visitors in the home, both visitors stated they found it warm in the home the previous week during hot weather days.

Air temperature records were provided from the LTC home's online monitoring system for a three week time period in 2023. The air temperatures in several resident rooms and common areas were recorded every hour and included numerous dates and times when the air temperatures were recorded at 26 degrees Celsius or above for consecutive hours and days.

In a resident's room on the second floor, the air temperature was recorded as 26 degrees Celsius or above, every hour for entire days. The air temperature in the resident's room reached as high as 28.5 degrees Celsius.

In one of the resident Activity Areas on the first floor, the air temperature was recorded as 26 degrees Celsius or above, every hour for entire days. The air temperature in the Activity Area reached as high as 29.5 degrees Celsius.

Hand-written notes on some of the pages of the air temperature records provided by the LTC home stated: Informed to close blinds; Fans provided; Windows closed; Thermostat adjusted; Adjusted hallway A/C.

In an interview, the Maintenance Supervisor indicated the air temperatures in the home should be maintained between 22 and 26 degrees Celsius. The Maintenance Supervisor indicated there was air conditioning in all parts of the building, however based on a recent HVAC inspection the air conditioning was not functioning at 100%, and it was functioning at 50 to 75%. When asked to explain which specific areas of the LTC home were affected by the air conditioning deficiencies, the Maintenance Supervisor provided 16 resident room numbers on each of the first, second and third floors of the home, for a total of 48 resident rooms. The Maintenance Supervisor also stated there were common areas impacted by the air conditioning deficiencies, including the resident Activity Rooms, and indicated the whole LTC home's central air conditioning system was impacted by the deficiencies as the air handling units that were in good repair were compensating for the areas that were deficient.

The Director of Care (DOC) indicated that it was a shock to see the recorded air temperatures that were recorded at 26 degrees Celsius and above when reviewing the temperature records with the inspectors. The DOC stated that when temperatures are out of range, the Maintenance Supervisor should be made aware and take further action and indicated that any air conditioning issues would be discussed in their morning meetings.

An HVAC maintenance report provided by the LTC home provided details for servicing and inspection of the HVAC system. The report noted deficiencies and defective parts in air handling units, as well as missing insulation and blown fuses.

The LTC home provided copies of four service proposals from the vendor for repairs to the HVAC system. All four service proposals were signed by the Administrator on the first date of the inspection.

There was an increased risk of heat related illness for residents as the licensee failed to ensure that the air conditioning in the home maintained the temperature at a comfortable level for residents, when the temperature in areas of the home measured by the licensee reached 26 degrees Celsius or above.

Sources:

Interviews with visitors and staff, Air Temperature Records, Environment and Climate Change Canada report, HVAC Maintenance Report and Vendor Service Proposals

[706026]

This order must be complied with by July 27, 2023.

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator

Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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