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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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 4, 2015	2015_346133_0042	O-002886-15	Complaint

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE STARWOOD
114 STARWOOD ROAD NEPEAN ON K2G 3N5

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 26th, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, the Maintenance Supervisor, the Maintenance Worker, registered and non registered nursing staff, and a resident.

During the inspection, the inspector monitored bedroom and hallway temperatures within a specified care unit, and reviewed email communications between the complainant and the Administrator.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 comply with O. Reg. 79/10, s. 21 in that the licensee failed to ensure that the home is maintained at a minimum temperature of 22 degrees Celsius (71.6 degrees Fahrenheit).

On October 5th, 2015, a complaint was received, by the Ministry of Health and Long

Term Care, related to temperature in the home. The complainant indicated that on October 3rd, 2015, it had been 69 degrees Fahrenheit (20.5 degrees Celsius) in resident #001's bedroom. In follow up conversations on October 8th and 9th, 2015, the complainant explained that there were 3 thermometers in resident #001's bedroom and that the temperature had been declining in resident #001's bedroom over the week of September 28th, 2015. The complainant further advised that in the spring of 2015, the temperature had been below 22 degrees Celsius for a period of 7 -10 consecutive days. The complainant explained to inspector #133 that in the spring, the maintenance manager and the Administrator had verified the temperature to be below 22 degrees Celsius in his/her presence. The complainant explained to inspector #133 that they understood the reason for the low temperatures to be related to the seasonal switch over between heating and cooling at the home. The complainant indicated that as of October 7th, 2015, they had noted the temperature in resident #001's bedroom to be at 22 degrees Celsius. The complainant provided inspector #133 with emails relating to low building temperatures in June and in September/October 2015, between the complainant and the home's Administrator.

On October 26th, 2015, inspector #133 began a complaint inspection at the home. The Administrator explained to the inspector that the home's HVAC system can deliver heating or cooling. If the system is set up for heating, there is no access to cooling. If the system is set up for cooling, there is no access to heating. An outside contractor is required to perform the switch over. The Administrator explained that the decision to make the switch, in the spring and the fall, is based on long range weather forecasts. The Administrator explained that in each resident bedroom, there is a heating/cooling unit (incremental unit), and each bedroom is also served by heated or cooled air from the roof top HVAC units, via a vent in the bedroom wall. The Administrator explained that this September, there were unusually high outdoor temperatures, and they had decided to keep the cooling function on longer than in past years. The Administrator indicated they had called for service for the switch to heat at some point during the week of September 28th, 2015, and had called again on October 5th, 2015, as they were aware that the building was cool. The Administrator indicated that the home did not have a process in place to monitor and document the temperatures throughout the building during this period. The Administrator stated she was not disputing the complainant's assertion that resident #001's bedroom was 69 degrees Fahrenheit (20.5 degrees Celsius) on October 3rd. Towards the end of the inspection day, behind the reception desk, the Administrator pointed out a centralized temperature display panel, which captures the average temperature within the hallways. The Administrator said it was normally around 73 degrees Fahrenheit (22.7 degrees Celsius) on the display panel, but she had noticed it

was down to 71 degrees Fahrenheit (21.6 degrees Celsius) at some point during the week of September 28th, 2015. The Administrator explained that during such times, when the heat had been turned off, or had not been turned on yet, and it became cool in the building, staff were expected to help residents to stay warm by ensuring they were dressed properly. The heat was turned on on October 5th, 2015.

Relating to building temperatures in early June 2015, the Administrator explained that the spring switch over had occurred in May, and therefore there was no access to heat at that time. The Administrator explained that the cooling system had been overactive, and temperatures were below 22 degrees Celsius. The Administrator explained that after she was made aware that resident #001 was cold in his/her room, on June 3rd, 2015, by the complainant, it was discovered that the thermostat on the incremental unit was broken. Replacement of the thermostat did not solve the problem, and the complainant emailed the Administrator again on June 7th, 2015, to inform that resident #001's bedroom was still cold, with a temperature in the bedroom of 19 degrees Celsius and 20 degrees Celsius in the bathroom. The Administrator explained to inspector #133 that it was then determined that there was a wider system issue. The cooling system for resident #001's care unit was turned off and new hallway sensors to better control the roof top units were installed over the following weeks. The Administrator stated to the inspector that she was not disputing that the temperature in resident #001's bedroom had been below 22 degrees Celsius. The Administrator explained that resident #001 is a person who often tends to feel cold, and she understood that resident #001 was cold during these times.

On October 26th, 2015, inspector #133 met with resident #001 in his/her bedroom. The temperature in the bedroom was approximately 25 degrees Celsius at the time, and the resident told the inspector that they felt warm. Resident #001 told the inspector that he/she had been very cold when the air conditioning came on that spring. Resident #001 told the inspector that in order to stay warm during that time, he/she had stayed in bed, with a heavy blanket and two sweaters on. Resident #001 explained that he/she had asked the complainant to make the Administrator aware of the problem, in early June 2015. Resident #001 told the inspector that he/she had also been cold before the heat came on, the first week of October. He/she explained that to stay warm, he/she wore a hat and three sweaters while in bed, or two sweaters over top of their pyjamas. Resident #001 explained that his/her family had brought in several thermometers for their bedroom and that he/she had been told it was 69 degrees Fahrenheit (20.5 degrees Celsius) in the bedroom, which he/she found too cool.

On October 26th, 2015, inspector #133 noted the temperature in bedrooms throughout

resident #001's care unit were in the range of 24 – 26 degree Celsius. [s. 21.]

Issued on this 4th day of November, 2015

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

Original report signed by the inspector.