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 West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: February 27, 2024
Original Report Issue Date: February 15, 2024
Inspection Number: 2024-1026-0001 (A1)
Inspection Type: Complaint Critical Incident
Licensee: Golden Years Nursing Homes (Cambridge) Inc.
Long Term Care Home and City: Golden Years Nursing Home, Cambridge

Amended By Kaitlyn Puklicz (000685)	**Inspector who Amended Digital Signature** Kaitlyn Joan Puklicz Digitally signed by Kaitlyn Joan Puklicz Date: 2024.02.29 09:15:33 -05'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Reflect an extension to the Compliance Due Date (CDD) to April 28, 2024. The Inspector has also corrected the numbering of each non-compliance (NC).

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Lead Inspector Kaitlyn Puklicz (000685)	**Additional Inspector(s)**
Amended By Kaitlyn Puklicz (000685)	**Inspector who Amended Digital Signature** Kaitlyn Joan Puklicz Digitally signed by Kaitlyn Joan Puklicz Date: 2024.02.29 09:16:04 -05'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Reflect an extension to the Compliance Due Date (CDD) to April 28, 2024. The Inspector has also corrected the numbering of each non-compliance (NC).

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 23 - 26, 29 - 31, 2024

The following intake(s) were inspected:

- Intake: #00101884 - Complaint related to fall measures and end of life care of a resident
- Intake: #00102985 - Fall of a resident resulting in injury and a significant change in condition

The following intakes were completed in this inspection: Intake: #00097721, CI #1033-000009-23 and Intake: #00101034, CI #1033-000011-23 related to resident falls resulting in injury and a significant change in condition.

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

Infection Prevention and Control
Safe and Secure Home
Palliative Care
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from neglect by

staff.

"Neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. O. Reg. 246/22, s. 7.

Rationale and Summary

A resident's plan of care included falls prevention strategies to ensure their safety.

The resident had an unwitnessed fall and was found on the floor of their room.

A housekeeping staff member stated they found the resident on the floor the day of their fall, and their body was touching their baseboard heater (BBH). The resident sustained an injury. The resident's room door had been closed and their falls interventions were not implemented at the time of the fall.

A Personal Support Worker (PSW) stated that due to the resident's condition, their door should not have been closed as it limited the ability of staff to visualize the resident and respond to the situation. Staff response was further compromised by one of their falls interventions not being in place. They stated this was not the first time this intervention was not completed as ordered.

The DOC acknowledged that falls interventions were not in place leading up to the resident's fall and their door was closed at the time of the incident. The DOC and other staff were aware of at least one fall mat being burned by the heater in the resident's room and yet nothing had been done to address the potential harm to a resident.

The lack of action whereby falls interventions were not implemented and a BBH known to be a safety risk was not addressed resulted in actual harm to a resident.

Sources: Complaint, clinical record for the resident, interview with a housekeeper, PSW, and the DOC.

[000685]

WRITTEN NOTIFICATION: Air temperature

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2) 1.
Air temperature
s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home.

The licensee has failed to ensure that the temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home.

Rationale and Summary

Air temperature logs for the home were reviewed and did not include readings for any resident rooms.

The DOC confirmed that the home had not been measuring air temperatures in resident rooms.

By not measuring resident room temperatures, there was a risk that rooms would be outside of the temperatures deemed safe for residents of the home.

Sources: Air temperature logs, observations, interview with the DOC.

[000685]

COMPLIANCE ORDER CO #001 Home to be safe, secure environment

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. Complete an audit of all electric baseboard heater thermostats to which residents have access in the home to determine which temperature gauge face plates no longer have visible temperature markings as per original installation. Ensure that the temperature gauge face plates clearly indicate the full range of temperatures (Off, 40, 50, 60, comfort zone, 80˚F) at the correct intervals. Each dial shall also have a clear marking that cannot be rubbed off so that staff know exactly what temperature the dial has to be rotated to. Maintain a record of this audit, including the date of the audit, the room number, which face plates require intervention, and actions taken.
2. Ensure there is a system in place (ie. lock box) in place to prevent residents and visitors from tampering with the thermostats and that the system only allows

specified staff to have access to adjust the thermostats.
3. Ensure that when the thermostats are adjusted to achieve a minimum of 71.6˚F (22˚C) for the room or space, that the baseboard heaters do not exceed a temperature that will cause resident harm (burn risk).
4. Develop a policy and procedure for the above assigned staff members to follow on the operation of the system, thermostats and the maximum allowable temperature settings for the baseboard heaters to prevent a burn risk to residents.
5. Ensure that all staff are made aware of the process of who will manage the thermostats and lock boxes, how to request temperature adjustments in resident spaces and the dangers associated with electric baseboard heaters (fire hazards and burn risks) when not managed adequately. A record of how staff were informed, when and by whom shall be maintained for review.
6. Develop an audit and document the settings of five random thermostats located in different resident spaces each week for four weeks to ensure that assigned staff are adhering to the procedure to keep the thermostats below maximum allowable temperature settings. Maintain the record for review.

The licensee has failed to ensure that the home was a safe and secure environment for its residents.

Rationale and Summary

A resident had an unwitnessed fall in their room.

A complaint was received alleging that the resident had been burned by the baseboard heater (BBH) in their room.

The resident was found on the floor next to the BBH with an injury.

The home's Skin and Wound Care lead believed the wound was a burn. They went into the resident's room five days after the incident and attempted to touch their BBH but they could not hold their hand on it as it was too hot.

During observations of the resident's room, the temperature of their BBH exceeded that of which can cause a severe second degree burn (>49 degrees Celsius). The temperatures measured were between 50.6 - 62.0 degrees Celsius. It was also noted that there were no covers over the thermostats in any resident rooms in that area of the home and many of the faceplates of the thermostats were so worn down that no numbers were visible. When the heater was on and actively heating the room, the Inspector was unable to touch the BBH for longer than a second due to the pain caused by the high heat.

A PSW stated all resident rooms in that area of the home have wall mounted heaters and that the home did not have any safety measures in place to prevent injuries with the heaters. They stated the resident's room heater posed a risk to their safety, especially as they were high risk for falls. The PSW stated items such as fall mats have been burned by the BBHs in resident rooms.

A maintenance employee confirmed that anyone can adjust a resident's thermostat. There was a possibility that staff, other residents or family members could adjust the thermostats to the hottest temperature, therefore causing the BBHs in the rooms to get dangerously hot to the touch. When they were informed about the dangerously high temperatures of a specific resident's BBH, they stated this could pose a burn risk to a person or an item depending on the temperature and the duration of exposure.

The DOC acknowledged that both staff and family had brought forward concerns that the resident was burned by the heater in their room and that the temperatures

of the resident's BBH posed a risk to the resident.

When there were no control measures in place to monitor the heat or danger associated with resident room heaters, residents were placed at risk of injury.

Sources: Complaint, observations, clinical record for the resident, interviews with a housekeeper, Skin and Wound Care lead, PSW, maintenance employee and the DOC.

[000685]

This order must be complied with by April 28, 2024

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.