Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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 # / No de registre	Type of Inspection / Genre d’inspection
Mar 2, 2018	2018_539120_0005	001579-18	Other

Licensee/Titulaire de permis

King Nursing Home Limited
49 Sterne Street Bolton ON L7E 1B9

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

King Nursing Home
49 Sterne Street Bolton ON L7E 1B9

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

BERNADETTE SUSNIK (120), HEATHER PRESTON (640)

Inspection Summary/Résumé de l’inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): February 23, 2018

Visits to the home were conducted on January 18, 23, 27, 2018, to ensure that actions were being taken to prepare the building and staff for the repatriation or re-admission of all residents beginning on February 1, 2018, following an evacuation of the residents from the home on January 5, 2018 related to a lack of heat and hot water. Inspections were conducted February 6, 14, 16, 23, 2018, to determine compliance with re-admission procedures and hot water and air temperature requirements. The inspections were completed concurrently with a follow up inspection associated with a complaint (inspection report #2017-482640-0025) which included four compliance orders for non-compliance identified between December 28, 2017 and January 5, 2018, related to a lack of heat and hot water.

During the course of the inspection, the inspector(s) spoke with the Administrator, Environmental Manager (EM), registered staff [Registered Practical Nurse (RPN) and Registered Nurse (RN)], personal support workers (PSW) and residents.

During the course of the inspection, the inspectors toured the home, verified air and water temperatures in resident accessible areas, reviewed water and air temperature logs, water temperature monitoring policies and procedures, internal maintenance request forms, external maintenance service reports, staffing plans and resident re-admission assessments.

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)**
- **1 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. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented to ensure that the temperature of the water serving all bathtubs, showers, and hand basins used by residents did not exceed 49 degrees Celsius, and was controlled by a device, inaccessible to residents, that regulated the temperature.

The Administrator provided a policy and procedure related to water temperature monitoring in the home (VII-H-10.70). It included the role of the Personal Support Worker (PSW) and registered staff in monitoring the water temperatures, how to notify maintenance staff and what actions to take should the water temperature fall below 40 degree Celsius (C) or rise above 49C. An additional and separate policy titled "Water Temperature Monitoring Tip Sheet" [VII-H-10.70(a)], included actions related to the restriction of water use by residents and their supervision around water tap use and to direct staff on other home areas to check and record hot water temperatures to determine if other areas of the building that are affected. Neither policy included information regarding how the domestic hot water system was regulated or controlled by a device, and how the hot water system would be controlled should the hot water temperature exceed 49C. The role of the Environmental Manager (EM) in one of the policies was limited to monitoring the water temperature until the temperature stabilized and once any adjustments or repairs were made, that the EM confirm the hot water temperatures were within range and notify staff and residents. The policy did not include details about the actions or options that were available to the EM in order to manage the domestic hot water system once temperatures exceeded 49C.

According to documentation provided by the Administrator, an estimate to install two new thermostatic mixing valves was acquired three weeks prior to the inspection. The Administrator stated that an order was placed and that it would take several weeks to acquire the mixing valves. During the inspection, the EM reported that the mixing valves to regulate the water temperature in the home were not functional, and the new valves had not been installed. As such, the water temperatures in the building were not being regulated or controlled by a device, but manually by either the EM or his designated maintenance person. The EM demonstrated how they were attempting to control the domestic hot water system and led inspector #120 to a thermostat. The thermostat was very small and had a tiny adjustable sliding lever. According to the EM, the lever was adjusted when staff identified water temperatures outside of the 40-49C range. The EM stated that if the lever was adjusted just a millimeter too much, it could and had offset the hot water temperature by 5C or 10C. Therefore, the control or regulation of the domestic hot water system was a challenge in ensuring that the water temperatures remained within the required range of 40-49C. The process demonstrated to the inspector was not identified in any of the policies related to the management and control of the domestic hot water system.

During the inspection, water temperature logs were reviewed for a period of time one week prior to the inspection. Hot water temperatures were recorded on each shift, in random areas to which residents had access, including the shower and tub rooms. The temperatures fluctuated up and down by 5C on a daily basis and ranged from 30C to 66C. On some, but not all of the dates, when water temperatures exceeded 49C, the EM documented that they had adjusted the thermostat down and identified that within a couple of hours, the temperature dropped by 10C to 15C. In some cases, the EM reported that the thermostat had to be re-adjusted a few hours later as the water temperature dropped below 40C.

The licensee therefore did not ensure that procedures were developed and implemented to ensure that the temperature of the water serving all bathtubs, showers, and hand basins used by residents did not exceed 49C, and was controlled by a device, inaccessible to residents, that regulated the temperature. [s. 90. (2) (g)]

2. The licensee failed to ensure that procedures were developed and implemented to ensure that immediate action was taken to reduce the water temperature in the event that it exceeded 49 degrees Celsius.

The licensee's procedure related to water temperature monitoring (VII-H-10.70) dated July 2015, included direction for registered staff, specifically the Registered Nurse (RN), to (1) monitor hot water temperatures in random resident home areas (resident bathrooms, tub rooms and public bathrooms) on each shift, (2), record the water temperatures on a specified form, (3), report all water temperatures below 40 degrees Celsius (C) or above 49C, and to document all reports and follow up in the "comments" column of the monitoring form, (4) if maintenance personnel is not available, to contact the Environmental Manager (EM), Director of Care (DOC) or Administrator and (5) to instruct all staff of the risks and what actions to take. Direction was also included for the EM or DOC to implement corrective actions, monitor the water temperature until it stabilized and was within range and to notify staff and residents of the result. An additional and separate policy titled "Water Temperature Monitoring Tip Sheet" [VII-H-10.70(a)], included actions related to the restriction of water use by residents and their supervision around water tap use and to direct staff on other home areas to check and record hot water temperatures to determine if other areas of the building that are affected. Neither policy included what actions to take to reduce the water temperature in the event that it exceeded 49C.

According to the EM, water temperatures over 49C required that the thermostat at the source be adjusted, as the hot water system was not controlled or regulated by a thermostatic device. However, only maintenance personnel had access to the thermostat and if the EM or other maintenance personnel were not in the building, action to reduce the water temperature was not immediate. Once the thermostat was adjusted, the EM reported that it took several hours to either lower or raise the hot water temperature. The EM was asked what other options would be immediately available to registered staff and the EM stated that running the hot water on a particular floor or location may have reduced the temperature, especially at night, when the hot water was not being used and circulated. The direction was not included in either of the policies provided for review.

According to RPN #103, RPN #106 and RN#107, if water temperatures exceeded 49C, their understanding of the process was to write a note in the "comments" section of the water temperature form that maintenance was made aware of the issue, either in person or by telephone or that a maintenance request was sent. The maintenance request was sent electronically to the EM via a maintenance software program. The information was subsequently accessed by a maintenance person or the EM, either on the same day or a subsequent day. Other immediate actions to have been reported as taken by registered staff, included advising all staff and residents that water temperatures were over 49C and

not to use the hot water taps. However, the registered staff interviewed were not aware of any immediate actions that could have been taken to reduce the water temperature.

According to water temperature logs acquired at the time of inspection, the hot water temperatures in all of the shower and tub rooms and some resident rooms exceeded 49C on each date one week prior to the inspection and were taken and documented by PSWs. The majority of the exceedences were recorded on the night shift, between 2300 and 0700 hours. The documentation was reviewed for all floors on one particular date in 2018, which included nine hot water temperatures recorded between 52.1C and 60C. The staff documented “maintenance request sent in” or the comments field was blank next to the temperature recorded.

Based on the documentation and interviews with staff, no immediate response to reduce the hot water temperature was taken. The hot water remained over 49C from 0030 hours to 1600 hours and affected all three floors. Only one maintenance request record was found by the EM on the home's maintenance software program related to temperatures taken on the same date of the incident, identifying that the water temperature was hot and did not list the affected area or room number. The response on the maintenance request form, which was dated six days after the incident, was that the temperature was adjusted and monitored every hour. No information could be provided as to who adjusted the hot water (if at all), when it was adjusted, and the temperature of the water after it was adjusted. No immediate action was documented other than the maintenance staff was made aware or that a request was sent. No follow up water temperatures were recorded by any staff member other than the water temperature during the following shift which was documented to be 46C and 44C for an identified tub and shower room at 1730 hours.

On the following day, six additional water temperatures were recorded to be between 52.8C and 60.2C. No maintenance requests were filed by registered staff and the comments were either blank or that a maintenance request was made. Manual notes made by the EM identified that the hot water was lowered or adjusted from 56C at the thermostat (no time provided) and that by 0900 hours, the water was at 49C. By 1100 hours, the hot water was 40.4C. By 2300 the water had reached 52.8C. No immediate action to reduce the hot water was documented other than the maintenance staff was made aware or that a request was sent. No follow up water temperatures were recorded by any staff member other than the water temperature during the following shift.

A repeat of the two previous day's temperature recordings and lack of follow up

comments were made on several additional dates, with similar outcomes. Either no maintenance requests were filed by registered staff and the hot water temperatures remained over 49C for a number of hours, or a maintenance request was filed by registered staff, asking maintenance to check the water and the follow up action included that the water temperature was adjusted and monitored, and the response times were delayed and the follow up temperatures not always recorded.

The licensee therefore did not ensure that procedures were developed and implemented to ensure that immediate action was taken to reduce the water temperature in the event that it exceeded 49 degrees Celsius. [s. 90. (2) (h)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented to ensure that the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature and that immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius, to be implemented voluntarily.

Issued on this 2nd day of March, 2018

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

Original report signed by the inspector.