Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 19, 2021	2021_778563_0016	012104-21	Critical Incident System

Licensee/Titulaire de permis

Kingsway Nursing Homes Limited
310 Queen Street East R.R. #6 St Marys ON N4X 1C8

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

Kingsway Lodge Nursing Home
310 Queen Street East, R.R. #6 St Marys ON N4X 1C8

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

MELANIE NORTHEY (563)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 16, 17 and 18, 2021

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Director of Environment, Environmental Aide, a Housekeeper, Registered Nurses, a Registered Practical Nurse, Personal Support Workers, Program Assistant, Receptionist, and a family member.

The inspector conducted a tour of the home and made observations of residents and care, meal and snack service, and resident/staff interactions. The inspector also observed the monitoring process for air temperature, as well as the infection prevention and control practices and active visitor screening. Relevant clinical records and procedures were also reviewed.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
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	Légende 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. Air temperature

Specifically failed to comply with the following:

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the air temperatures were measured and documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Kingsway Lodge long-term care home had central air conditioning throughout the home, therefore air temperatures were to be measured and documented in writing in at least two resident bedrooms in different parts of the home and one resident common area on every floor of the home, which may include a lounge, dining area or corridor. The home did not have designated cooling areas since central air conditioning was in every resident room, hallway, and lounge.

The air temperature monitoring log only accounted for the measurement and documentation of air temperatures once every day shift and once every afternoon between 12 p.m. and 5 p.m. The home was not measuring and documenting air temperatures once every evening or night.

The Director of Environment verified the home was not measuring and documenting the air temperatures once every evening or night for second and third floor in any resident common area or resident rooms in July and August 2021.

Sources: July and August 2021 air temperature log for second and third floor and interview with the Director of Environment. [s. 21. (3)]

Issued on this 19th day of August, 2021

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

Original report signed by the inspector.