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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 19, 2013	2013_304133_0034	O-001128-13	Follow up

Licensee/Titulaire de permis

MAXVILLE MANOR
80 Mechanic Street, MAXVILLE, ON, K0C-1T0

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

MAXVILLE MANOR
80 MECHANIC STREET WEST, MAXVILLE, ON, K0C-1T0

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 Follow up inspection.

This inspection was conducted on the following date(s): December 12th, 2013

During the course of the inspection, the inspector(s) spoke with The Administrator, the Environmental Services Manager, nursing staff, and residents.

During the course of the inspection, the inspector(s) conducted several walkabouts of the home, in order to ensure that doors leading into non residential areas were kept closed and locked when not supervised in order to restrict resident access to those areas. As well, the inspector monitored air temperatures throughout the original sections of the home, with an emphasis on the secured units; Stormont and Glengarry.

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

Findings of Non-Compliance were found during this inspection.

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 has failed to ensure that the home is maintained at a minimum temperature of 22 degrees Celsius, primarily within the home's secured care units, Glengarry and Stormont .

On December 12th, 2013, during the inspection, the inspector monitored air temperatures in identified areas. It is noted that in hallways throughout the home, as well as in common areas such as the resident lounge in the Prescott care unit and the Glengarry care unit, there are no independent heat sources. Heat radiating from

resident bedrooms, as well as heat that may be released from the exit door vestibules at the end of each hallway, when the inner door is opened, is the only potential source of heat for such areas. A sign on the door into the Glengarry care unit resident lounge reads "Please leave the door open, otherwise the room is cool for residents during program. Thank you for your cooperation".

Air temperatures were taken with the inspector's thermometer, after allowing it to sit for a period of, at minimum, 5 minutes. The following temperatures were found in the following areas at the following times:

Glengarry care unit resident lounge, at 12:16pm – 20.1 degrees Celsius. There is no heat source within this room. The door leading into the lounge was open, and the air temperature in the hallway in the immediate area leading to the lounge, between bedrooms #318 and #319, was 21.7 degrees Celsius.

Glengarry care unit hallway, outside of bedroom 330, at 12:21pm – 21.1 degrees Celsius

Bedroom #330, Glengarry care unit, at 12:26pm – 21.4 degrees Celsius

Bedroom #334, Glengarry care unit, at 12:33 – 21 degrees Celsius. The inspector noted that the thermostat was set at approximately 20.5 degrees Celsius. Care unit nursing staff are expected to ensure that thermostats are set appropriately.

Bedroom #322, Glengarry care unit, at 12:40pm – 21 degrees Celsius. The bedroom thermostat was set for 26 degrees Celsius, and was indicating a temperature of slightly below 20 degrees Celsius. The inspector was flagged to this room as when the inspector passed by, it could be observed from the hallway that there were sheets piled up along the base of the bedroom window, and a picture had been placed over top of the fresh air vent that is underneath the heat radiator. A Personal Support Worker, staff member # S100, in the immediate area informed the inspector that they had reported this room to the Environmental Services Manager (ESM) because it seemed cold, and that they had noted that the resident had covered the base of the window and fresh air vent as described above. At approximately 3:30pm, the inspector and the ESM went to this room together. The ESM explained he had attempted to improve the heat in the bedroom, but it was noted at that time that his interventions had not yet been successful, and the bedroom thermostat still indicated a temperature of 20 degrees Celsius.

Bedroom #224, Stormont care unit, 12:59pm – 20.9 degrees Celsius . The inspector noted that the thermostat was not set to call for any heat. The ESM and the inspector later returned to this room, and the ESM determined the thermostat was functional. Care unit nursing staff are expected to ensure that thermostats are set appropriately.

Prescott care unit resident lounge, at 1:13pm – 21.3 degrees Celsius. There is no heat source within this room; doors to the hallway on either side of the room were open. The air temperature in the hallway, outside of bedroom #520, was 21.9 degrees Celsius.

2. The licensee has a history of non-compliance related to air temperature, O. Reg. 79/10, s.21. On November 15th 2013, as a result of inspection 2013_304133_0032, a Written Notification and Voluntary Plan of Correction was issued to the home, in relation to air temperatures within the original sections of the home (Prescott, Osie F. Villeneuve, Stormont and Glengarry care units). [s. 21.]

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 with the requirement that, at all times, all areas of the home are maintained at a minimum temperature of 22 degrees Celsius. Specific focus is required in the area of thermostat settings and ongoing monitoring of such, and with regards to providing heat into areas that are not currently equipped with an independent heat source, such as hallways, the Glengarry resident lounge and the Prescott resident lounge, to be implemented voluntarily.

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:

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REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 9. (1)	CO #002	2013_204133_0012	133
O.Reg 79/10 s. 9. (1)	CO #001	2013_304133_0032	133

Issued on this 19th day of December, 2013

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

Jessica Lapensée