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
Jan 17, 2020	2020_788721_0001	000063-20	Complaint

Licensee/Titulaire de permis

CVH (No. 8) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Queensway Long Term Care Home
100 Queen Street East P.O. Box 369 HENSALL ON N0M 1X0

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

MEAGAN MCGREGOR (721)

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): January 6 and 7, 2020.

The following Complaint and Critical Incident (CI) intake was completed within this inspection:

Log #000063-20/Infoline #IL-73332-LO/Infoline #IL-73345-LO/CI #0933-000001-20 related to a loss of heating in the home.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Environmental Services Manager, a Registered Nurse, a Registered Practical Nurse, a Personal Care Aide, a maintenance staff member and residents.

The Inspector also observed residents and the care provided to them, heating equipment and measures in place related to temperature monitoring in the home and reviewed relevant records and policies related to the home's heating system and maintenance program.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance

During the course of this inspection, Non-Compliances were issued.
- **2 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. 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 ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

The Ministry of Long-Term Care (MLTC) received two anonymous complaints on January

1 and January 2, 2020, which included concerns related to the home being without heat since the week prior.

On January 2, 2020, the home submitted Critical Incident System (CIS) report #0933-000001-20 related to a breakdown of the home's heating system on December 28, 2019. The CIS report stated that one of the two boilers which provides heat to the home was shut off due to higher than normal carbon monoxide levels measured on December 28, 2019. It was documented that the identified boiler remained out of service at the time the CIS report was submitted. Residents had been provided individual heaters and the temperature of the second boiler was elevated to maintain temperatures in the areas of the home heated by the boiler which was out of service.

During an interview on January 7, 2020, maintenance staff member #106 told Inspector #721 that heat was provided throughout the home by two boilers. Maintenance staff member #106 stated that there were three wings in the home and that boiler #1 heated Wing C and part of Wing B, and boiler #2 heated Wing C and part of Wing B. They said that boiler #1 was shut off on December 28, 2019, when higher than normal carbon monoxide levels were measured in the boiler room and soot was observed on this boiler. Maintenance staff member #106 stated that boiler #1 had remained shut off since this date and that it was being replaced with a new boiler on January 7, 2020.

During an interview on January 6, 2020, when asked what the home's process was for monitoring temperatures in the home, Registered Practical Nurse (RPN) #104 said RPN's working the evening shift were responsible for recording temperatures from wall thermostats once per shift on a regular basis and that since the problems with the homes heating system started the Registered Nurse (RN) was monitoring every two to four hours on every shift. RPN #104 stated that when the boiler was first shut off only the temperature in Wing B was affected, at which time residents whose rooms were cold were provided individual heaters. They further stated that within a few days of the boiler being shut off the temperature in Wing C started to get cool and residents with rooms in Wing C were then provided with heaters. When asked what the temperature of the home was at this time, RPN #104 said the temperature may have been between and 18 and 20 degrees Celsius and that once the heaters were brought in it came up quickly.

On January 6, 2020, at 1140 hours Inspector #721 obtained temperature records from RN #105. A review of the home's temperature records showed the following between December 28, 2019, and January 6, 2020:
- Temperatures were recorded in the hallways of Wings A, B and C on 144 occurrences

and indicated temperatures were maintained at a minimum of 22 degrees Celsius on all occurrences.
- Temperatures were recorded in a lounge on Wing C on 65 occurrences and indicated temperatures were below 22 degrees Celsius on 21 occurrences.
- Temperatures were recorded in rooms 111, 112, 114, 115, 116, 127, 130, 131, 132, 133, 134, 136, 137, 138, 139, and 144 on Wings B and C on 439 occurrences and indicated temperatures were below 22 degrees Celsius on 65 occurrences.

During an interview on January 6, 2020, when asked what temperature they expected the home to be maintained at, Executive Director (ED) #100 stated they expected the temperature to be maintained at a minimum of 22 degrees Celsius. When asked how they were ensuring that the home was maintained at a minimum temperature of 22 degrees Celsius during the identified time when there was a breakdown of the home's heating system, ED #100 said that routine temperature audits were completed every 2 hours and that once a temperature of 23 degrees Celsius or higher was reached they were completed every 4 hours. When asked if they were aware of any occurrences where the air temperature in the home was below 22 degrees Celsius during the identified time when there was a breakdown of the home's heating system, ED #100 stated they were aware of one occurrence where the temperature was approximately 20 degrees Celsius in a residents room.

The licensee failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius on 86 of 648 documented occurrences during the time when there was a breakdown of the home's heating system between December 28, 2019, and January 6, 2020. [s. 21.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed within one business day of the occurrence of a breakdown of major equipment in the home for a period greater than six hours.

The MLTC received two anonymous complaints on January 1 and January 2, 2020, which included concerns related to the home being without heat since the week prior.

On January 2, 2020, the home submitted CIS report #0933-000001-20 related to a breakdown of the home's heating system on December 28, 2019. The CIS report stated that one of the two boilers which provides heat to the home was shut off due to higher than normal carbon monoxide levels measured on December 28, 2019. It was documented that the identified boiler remained out of service at the time the CIS report was submitted.

A review of the Extendicare Policy titled "HVAC Systems Disruptions/Failure", policy #EP-13-01-01, last updated January 2019, stated in part that in the event of a Heating, Ventilation, Air Conditioning (HVAC) system malfunction or breakdown the Incident Manager was to complete a Critical Incident (CI) report, outlining the cause and length of the outage and the solutions implemented to restore the HVAC. It was further stated that reports were to be completed for all HVAC failures that last more than two hours and/or where the temperature drops below 22 degrees Celsius.

During an interview on January 7, 2020, maintenance staff member #106 told Inspector #721 that heat was provided throughout the home by two boilers. Maintenance staff member #106 stated that there were three wings in the home and that boiler #1 heated Wing C and part of Wing B, and boiler #2 heated Wing C and part of Wing B. They said that boiler #1 was shut off on December 28, 2019, when higher than normal carbon monoxide levels were measured in the boiler room and soot was observed on this boiler. Maintenance staff member #106 stated that boiler #1 had remained shut off since this date and that it would be replaced with a new boiler on January 7, 2020.

During an interview on January 6, 2020, when asked what the home’s process for notifying the MLTC of critical incidents, ED #100 stated they would usually submit CIS reports and would follow the reporting guidelines that had been provided by the Director. When asked what their understanding was of the reporting requirements related to a breakdown of the home’s heating system, ED #100 said that at the time when boiler #1 was shut off it was their understanding they were required to report a CI if they lost all heating in the home for six or more hours and didn’t think they were required to report a partial breakdown of the homes heating system. When asked if they would expect that a CI should have been submitted to the Director within one business day of boiler #1 being shut down on December 28, 2019, ED #100 stated it should have been reported.

The licensee failed to ensure that the Director was informed within one business day of the occurrence of a breakdown of the homes heating system for a period greater than six hours on December 28, 2019. [s. 107. (3) 2. ii.]

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Issued on this 17th day of January, 2020

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

Original report signed by the inspector.