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: August 9, 2023
Original Report Issue Date: August 2, 2023
Inspection Number: 2023-1020-0004 (A1)
Inspection Type: Complaint
Licensee: Sharon Farms & Enterprises Limited
Long Term Care Home and City: Strathcona Long Term Care, Mount Forest

Amended By	**Inspector who Amended Digital Signature**
Bernadette Susnik (120)	Bernadette Susnik Digitally signed by Bernadette Susnik Date: 2023.08.09 09:03:13 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to: Compliance due date for non-compliance (NC) #4 extended to September 1, 2023.

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Lead Inspector Bernadette Susnik (120)	**Additional Inspector(s)**
Amended By Bernadette Susnik (120)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to: Compliance due date for non-compliance (NC) #004 extended to September 1, 2023.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 19, 2023
The inspection occurred offsite on the following date(s): June 27, 28, 29, 2023

The following intake(s) were inspected:

- Intake: #00089440 and #00091836 - Complaints related to elevated air temperatures in resident rooms.

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

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Doors in a home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. iii.

The licensee has failed to ensure that all doors leading to stairways and to the outside of the home (which led to unsecure areas) to which residents had access, were equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation.

Rationale and Summary

All stairwell doors and the door to the front main entrance did not function as intended. Back-up alarms that were installed at these doors ceased to alarm when the doors self-closed. The alarms were not programed or designed to be cancelled only at the point of activation by a staff member.

Failure to ensure that the alarm sounds on all doors leading to stairways and to unsecure outdoor areas may increase the likelihood of residents eloping without staff knowledge.

Sources: Testing of the doors and interview with the licensee owner.
[120]

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 (3)

The licensee has failed to measure and document the temperature for the areas identified under s. 24 (2) at least once every morning, once every afternoon between 12 p.m. and 5 p.m.

and once every evening or night.

Rationale and Summary

The areas identified under s. 24 (2) include at least two resident bedrooms in different parts of the home and a common area (which may also be a designated cooling area) on each floor, at a minimum. Temperature records for the third floor for the month of June 2023 did not include temperatures taken of any common areas. The 2nd and 3rd floor temperature records did not include air temperature measurements for a common area in the morning, evening, or night. The common areas selected also included a nurse's station, which was not a resident common area. Resident rooms when selected for monitoring, were mostly monitored only once per day, instead of three times per day as required.

Sources: Review of June 2023 air temperature records, interview with staff.
[120]

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 11.

The licensee has failed to ensure that the plan of care for residents #001, #002 and #003 included protective measures required to prevent or mitigate heat related illness.

Rationale and Summary

The interventions in the care plans for all three residents, which were assessed as either high, moderate or low risk for heat related illness were identical, despite each resident having different needs, medical diagnoses and preferences. They all included general response measures that were predominantly limited to residents being outdoors or clinical interventions to alleviate or mitigate symptoms. These included; monitor for heat-related symptoms; encourage resident to wear light weight clothing; and encourage resident to stay in cooler areas of the building. Resident rooms are now required to be served by air conditioning equipment and therefore encouraging a resident to go to a cooler area of the building has been

eliminated as an option. No protective measures to prevent heat related illness (if and when necessary) were identified for any of the three residents while in their rooms.

Environmental risk factors and interventions were not incorporated into the decision making when the plan of care was developed for residents #001, #002 and #003.

Failure to assess the resident's environment in addition to clinical risk factors and to subsequently include the protective measures in the plan of care for staff awareness may increase the resident's risk to heat-related illness.

Sources: Observations, interviews with staff, residents and families, review of care plans, progress notes and heat assessments. [120]

COMPLIANCE ORDER CO #001 Air conditioning requirements

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 23.1 (3) 1.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall complete the following:

1. Air temperatures are to be monitored and recorded in one dining room per floor and in five identified resident rooms on the first floor, six on the second floor and eight on the third floor three times daily to ensure cooling is at a comfortable level for residents. Continue to monitor and record air temperatures in the above noted areas until September 15, 2023. Where air temperatures are recorded to be 26°C or above, documentation shall be made as to the action taken to determine if the air temperature remained to be comfortable for the resident and when supplemental air conditioning equipment was installed or uninstalled where necessary. The documentation shall be made available for review during subsequent inspections.

2. Training and orientation shall be provided to any staff members who are required to monitor and adjust air temperature systems in the building to ensure that resident rooms remain at comfortable temperatures for the residents year-round. A record shall be kept as to who

attended the training, the dates of the training, the topics that were included in the training and who provided the training.

3. Supplemental portable air conditioning units are to be installed in resident rooms when or where the roof top air conditioning units are not capable of reducing the room temperature below 26°C, as per the permission of residents and/or their substitute decision makers. Portable air conditioning units shall be readily available to staff to promote timely installation where and when necessary. The installation or uninstallation of the supplemental air conditioning units shall be documented in the resident's progress notes and the reasons why. Where a portable air conditioning unit has been installed in a particular resident room, the fact shall be stated in the resident's plan of care, along with any operational directions for staff to follow if there are any.

Grounds

The licensee has failed to ensure that air conditioning was operating in resident rooms when needed to maintain the temperature at a comfortable level for residents between May 15 and September 15, on any day when the indoor air temperatures reached 26 degrees Celsius (°C) at any point during the day.

Rationale and Summary

The licensee was equipped with two air handling units (AHU), one for each side of the building which were designed to provide adequate air conditioning to resident rooms according to engineering records.

Two complaints were received regarding elevated air temperatures in resident rooms between the beginning of June and the beginning of July 2023. The complainants reported that no protective measures were initiated (i.e., use of air conditioning) for residents prior to May 15, 2023, when air conditioning was to be installed and operational for any days when indoor or outdoor air temperatures exceeded 26°C.

During the first week of June 2023, the licensee's air temperature records that were provided included documented measurements of 26°C and greater in eleven identified resident bedrooms. During the inspection, resident rooms were randomly selected, and the air

temperatures were measured to be 26°C or greater in eight of the rooms. The outdoor air temperature beginning at 9:30 a.m. was 23.3°C and 24.9°C at 1:15 p.m. and the air supply serving the resident rooms was 20.7°C and increased to 23°C as the day progressed.

Resident #001 reported to the administrator on a specified date in June 2023, that they had symptoms during periods of elevated air temperatures in their room (when over 26°C). During the inspection, the resident's room was noted to be above a space that generated heat, and the room below was over 35°C. Staff recorded air temperatures of 26°C or 27°C on four different days in June 2023. The inspector measured the air temperature during the inspection at two different times of the day and it was 26.5°C. At the time of inspection, no documentation was included on the temperature log, in clinical progress notes or any other record as to the course of action taken for the resident that was protective in nature. A few days after the inspection, a progress note was made by staff #101 that the resident was complaining about the heat in their room. The resident received a portable air conditioner after the inspection was completed.

A family member reported that resident #006 resided in a room also above a space that generated heat. They reported that the resident had heat-related symptoms during periods of elevated air temperatures. Although no formal complaint to the management staff was made, the complainant stated that all the staff knew how hot it was in resident rooms. During the inspection, the resident's room was observed to have heat-generating medical devices (which emitted additional heat at 37°C). The room thermostat was reading 26.5°C.

It was also noted that the radiant hot water heating panels located on the ceiling of resident rooms were on in many rooms and emitted heat. Five resident rooms additionally were located directly above a space that generated heat and were subject to increased radiant heat which was emanating through the floor. Several resident rooms also had heat-generating medical devices that additionally added heat to their rooms. Although most residents had fans, and the Director of Care reported that residents were provided with popsicles, cool fluids, and encouraged to use the designated cooling areas, no action was taken to ensure that the temperatures in resident rooms were at a comfortable level for the residents until the inspector raised concerns.

A maintenance lead with skills and knowledge to adjust and monitor the AHUs to ensure they were operating to provide adequate cooling had not been employed at the home since April 6, 2023. Other staff members were required to manage the system without adequate training or

experience.

Failure to monitor resident rooms adequately and to ensure that both the AHUs were operating as designed and needed to maintain comfortable temperatures for residents inside the home increased the risk of heat-related illness for residents.

Sources: Direct air temperature measurements using an ambient air thermometer and surface infrared thermometer of resident rooms, common areas and boiler room, review of air temperature records, engineering records, interview with staff, residents, family, licensee owner, Director of Care and Administrator. [120]

This order must be complied with by September 1, 2023

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.