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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Feb 8, 2018	2018_687607_0001	000277-18, 000398-18, 000630-18, 000666-18	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

ReachView Village
130 Reach Street UXBRIDGE ON L9P 1L3

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

JULIET MANDERSON-GRAY (607)

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 9 and 11, 2018

During this Complaint inspection, the following logs were reviewed and inspected: Log #'s 000277-18, 000398-18, 000666-18 and 000630-18.

Summary of Logs:
1) Log #000277-18, a Critical Incident Report (CIR) related to an environmental hazard.
2) Log #000398-18, a CIR related to an environmental hazard.
3) Log #000666-18, a CIR related to an environmental hazard.
4) Log #000630-18, a Complaint related to heating in the home.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Environmental Services Managers (ESMs), Registered Nurses (RN), Personal Support Workers (PSW), residents and families.

During the course of this inspection, the Inspector reviewed applicable polices related to environmental services, the LongTerm Care home air temperatures and hot water temperatures logs, and Emergency plan.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **3 VPC(s)**
- **2 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. 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 temperature in the home was maintained at a minimum of 22 degrees Celsius (C).

Related to Log # 000630-18:

An anonymous complaint was submitted to the Director, indicating that the heat system in the Long-Term Care home was not functioning well, several resident rooms were cold measuring 15 (C) and there had been a few pipes that had burst. Residents were complaining about how cold it was in the home and nothing was being done.

A review of the Air Temperature and Humidity Logs directs:
Air temperature to be maintained at a minimum of 22 degrees.
Immediate action to be taken if temperatures exceeded parameters - Notify the Environmental or Manager on call. Do not continue baths until rectified.

A review of the Air Temperature and Humidity Logs indicated that there were five days in December 2017, and six days on eight different shifts in January in 2018, where the air temperatures were noted to be below 22 degrees (C).
The Air Temperature and Humidity Logs indicated the air temperatures in residents rooms were only monitored twice in December 2017, and was not monitored on identified dates in January 2018, despite resident complaints that the home was cold.

On an identified date and times in 2018, the Inspector observed the following air temperatures to be below 22 degrees (C):
- The thermostat located in an identified resident's room indicated the room temperature was 21 degrees (C). There were two residents that resided in the room at the time.
- In a second identified resident's room, noted cold air drafts felt coming from the closed window. A blanket was observed along the base of the window sill. There were two residents residing in the room at the time. Room temperature was 21 degrees (C).
- In a third identified resident's room, noted cold air drafts felt coming from the closed window. The room temperature was 19 (C).Transparent tape was observed around the entire parameter of the window where draft was felt as well as blanket along the base of the window sill.

On an identified date and time, the Inspector observed the ESM #107 applying weather strips to the windows in an identified resident's room

During an interview with resident #003, indicated that it was cold in the residents room and the building for about two weeks in December 2017, and the first week in January 2018. Resident #003 indicated complaining to staff and management and nothing was done. Resident #003 indicated that extra blankets was not given. The resident also indicated the heat was turned up on an identified date in 2018, when the Inspector arrived.

During an interview with resident #012 on an identified date, indicated it was cold for about two weeks in the month of December 2017, and the first week in January 2018. The resident indicated having to ring the call bell to ask staff for extra blankets.

During interviews, residents #006, #007, #008, and #011, indicated that it was cold in their rooms at times, as cold air draft came through the windows even though they were closed. Resident #008 also indicated that the latch on one of the window was broken causing cold air drafts.

During an interview, the ESM #107, indicated that the ESM had not had a chance to perform resident's room window audits in the home as they were too busy. The ESM also indicated not being aware that residents were complaining they were cold and if this was brought to the ESMs' attention the issue would have been addressed. The Inspector provided the ESM the list of rooms that was noted to have cold drafts coming from the windows. The ESM indicated that the window in resident room #017 did not need sealing with weather stripping as a family had already sealed the windows. The ESM indicated the family member had purchased the wrong weather strips for the window.

During an interview, the ED indicated that the previous ESM was responsible for maintaining the components of the windows. The ED further indicated there were no resident room audits completed since the residents of the home complained that they were cold.

Review of the air temperature logs completed in the home and direct observations of air temperature in residents rooms by the Inspector, confirmed the air temperatures were not maintained at a minimum temperature of 22 degrees (C), despite ongoing resident complaints regarding cold air temperature. [s. 21.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 ensuring that the temperature in the home maintained at a minimum of 22 degrees Celsius, to be implemented voluntarily.

WN #2: 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).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the policy and procedures for water temperatures related to the water serving all bathtubs, showers, and hand basins used by residents, includes temperatures that does not exceed 49 degrees Celsius (C) and the temperature of the hot water serving all bathtubs and showers used by residents was maintained at a

temperature of at least 40 degrees Celsius, was implemented.

Related to Log # 000277-18 and #000666-18:

Two Critical Incident Reports (CIR) were submitted to the Director on two identified dates, for environmental hazards. The first CIR indicated there was a leaking water pipe in the ceiling and the water was shut off for 1.5 hours. The second CIR was a water leak in a communal washroom and the water was shut off for less than six hours.

A review of the home's policy titled Care, policy # Care 14-010.02, (page 1 of 5) directs:
- Safe water temperature for staff assisted bath and shower is 38 degrees - 43 degrees Celsius.
- A daily water temperature check is performed and recorded before each first bath of the day.
- At a minimum three (3) water temperature checks carried out before immersing a resident into the tub or shower.
- The bath/shower Water Temperature Log will be used to record all water temperature.
- Water temperature checks that are outside the safe water temperature range will be reported immediately to the manager and maintenance. The identified tub or shower will be tagged out of service.

During an interview, PSW #103 indicated that water temperatures were monitored in the tub/baths areas prior to a resident bath. PSW further indicated the tub in each bath area has a sensor that would indicate how hot or cold the water temperature was. The PSW also indicated that documentation was completed of the water temperatures of the residents' tubs on log/sheet located in the tub rooms. The PSW indicated that if the water temperature in the tub was over 40 degrees (C), it would be too hot for the residents. The PSW also indicated that a water temperature of 32 degrees (C) or lower would be too cold for the residents. The PSW further indicated if the water temperature was below 32 degrees (C), this would be communicated to the charge nurse on the unit, and if water temperature was above 40 degrees (C), the PSW can adjust the temperature of water using the tap that was located by the tub.

During an interview, PSW #102 indicated a thermometer located by the residents' bath tubs was used to monitor water temperatures every time they completed a bath for the residents. PSW #102 also indicated these temperatures were being recorded on a log located in the bath/shower room. The PSW also indicated that a temperature of 38.7 degrees (C) was a normal temperature for the residents, and indicated water

temperatures above 38.7 degrees (C) would be too hot for the residents. PSW #102 also indicated that if the temperature was above 38.7 degrees (C) that they would not use the bathtub for residents' baths.

During an interview, PSW #109 indicated that prior to residents taking a bath/shower, water temperatures were being monitored in bathtubs, and once temperatures were taken they were logged on a sheet located in the bath area. The PSW indicated that if the water was not suitable for the residents, then the residents were bathed in another home area.

A review of the hot water temperatures monitored in the shower/tub areas for each unit that were below a minimum of 40 degrees (C) in January in 2018, indicated the following:

-Cedar Grove unit: on five identified dates in January 2018 the temperatures logged were: first date: 36.5, 39.1, 38.4 and 38.7 degrees (C); second date: 34.12 and 34.12 degrees (C); third date: 38.2, 38.1, 38.1 and 37.8 degrees (C); fourth date: 38.1 degrees (C); fifth date: 35.5, 34.0, 33.32, 37.2, 39.6 and 32.9, degrees (C). There were no documented hot water temperatures indicated for three identified dates in January 2018 prior to the inspection.

-Cardinal Court Unit: on two identified dates in January 2018 the temperatures logged were: first date: 37.3, 37.0, 37.8; 37.6 X 2, 37.3, 36.3 X 2, 37.6 and 37.5 degrees (C); second date: 34.8; 38.1; 37.5 x 2; 39, 34.1, 37.1 and 30.4 degrees (C). There were no documented hot water temperatures indicated for nine identified dates in January 2018.

-Blue Jay Boulevard Unit: On three identified dates in January 2018 the temperatures logged were: first date: 30 degrees (C) x 2, 31 and 30 degrees (C) x 3, 36.6 and 37.8 degree (C). There were no documented hot water temperatures indicated for five identified dates in January 2018.

-Spruce Unit: on two identified dates in January 2018 the temperatures logged were: first date: 39.5 and 35.8 degrees (C); and the second date: 38.0 and 37.0 degree (C). There were no documented hot water temperatures on nine identified dates in January 2018. This unit has two tubs but only one log was provided for the tub area and it was unclear which tub the water temperatures were monitored for.

2. A review of the Bath/Shower Water Temperature Logs indicated the following procedures: minimum temperature of resident water is 40 degrees Celsius and maximum

temperature is to be 49 degrees Celsius. Immediate action to be taken if water temperatures exceed parameters: notify the Environmental or Manager on call. Do not continue baths until rectified.

The water temperature logs for December 2017 and January 2018, were reviewed and the following hot water temperatures in resident sinks were noted to exceed the water temperature parameters:

In 22 resident's room sinks the temperatures were as follows: 49.8 degrees (C); 61.5 degrees (C); 52.3 degrees (C); 56.1 degrees (C); 49.8 degrees (C); 55.6 degrees (C); 51.2 degrees; 49.9 degrees (C); 49.8 degrees (C); 55.8 degrees (C); 50.1 degrees (C); 49.6 degrees (C); 50. 3 degrees (C); 50.3 degrees (C); 49.6 degrees (C); 58.1 degrees (C); 49.5 degrees (C); 49.2 degrees (C); 54.1 degrees (C); 49.1 degrees (C); 49.1 degrees (C); and 50.2 degrees (C).

In 10 resident's communal washroom sinks the temperatures were as follows: 52.9 degrees (C); 49.3 degrees (C); 61.3 degrees (C) x 2; 56.8 degrees (C); 49.2 degrees (C); 49.3 degrees (C); 52.6 degrees (C); 55.6 degrees (C); and 63.8 degrees (C).

On an identified date in January 2018, the Inspector monitored water temperatures and calibrated the thermometer used by the home to monitor water temperatures to be at 0.0 degrees (C) when placed in a glass of cold water for five minutes. The following areas were noted to have hot water temperatures that exceeded 49 degrees (C):

- On the Blue Jay unit, a resident communal washroom sink (where one of the pipes was leaking), the water temperature was 51.3 degrees (C).
- On the Cedar Grove unit, a resident communal washroom sink, the water temperature was 60 degrees (C).
- On the Cardinal Court unit, a resident tub, the water temperature was 52 .8 degrees (C).

During an interview, RN #102 and #108 who worked on two identified shifts indicated that whenever the water temperature exceeded 49 degrees or was below 40 degrees (C) in residents home areas, they would notify the Environmental Service Manger (ESM) or a Manager on call, and indicated the water temperatures that had exceeded 49 degrees (C) was reported to the ESM who previously worked at the home.

During an interview with the Executive Director (ED) indicated the Environmental Service

Manager #112 would have been notified of the above water temperatures that exceeded 49 or were below 40 degrees (C). The ED indicated ESM #112 was no longer working at the home. The ED also indicated that ESM #106 was covering after ESM #112 left the home. The ED further indicated not being sure of what actions were taken by the ESMs at the time staff reported the water temperatures that were below or exceeded the parameters. During further interview, the ED indicated that the expectation was that staff notified the ESMs whenever water temperatures exceeded 49 or were below 40 degrees (C), and that the ESM should have taken appropriate action. The ED also indicated that if the tub or sink water was too hot or too cold, the PSWs were to report this to the RN. The RN would report this to the ESM, and the ESM would then check the source and take appropriate action. The ED further indicated that if the ESM was not on site, then the staff were to contact the ESM by phone for further directions.

During an interview, the ESM #106 who was covering the home after ESM #112 left, indicated that no one had notified ESM #106 of water temperatures in resident home areas that had exceeded 49 or were below 40 degrees (C) in the month of December 2017 or January 2018. During the same interview, the ESM Manager #107, indicated being recently hired at the home. During interviews with ESM #106 and #107, both indicated that at present, there was a problem with the mixing valve being stuck at 43 degrees (C) and should have been reading between 40 and 50 degrees (C) when in normal operation. Both ESMs indicated, the valve being stuck at 43 degrees (C) would have affected current water temperatures in the home. They both indicated that if the resident's area water temperature was above 60 degrees (C) they would have someone come in to repair the valve immediately. The ESMs further indicated that they were not aware of water temperatures being above or below the required parameters, as no staff at the home had contacted them regarding this issue.

Review of the Bath/Shower Temperature logs completed in the home and direct observations of water temperatures in residents bath/shower areas by the Inspector, confirmed the water temperatures were not maintained at a minimum temperature of 40 degrees (C), or had exceeded 49 degrees (C). Interviews with ESMs #106 and #107 indicated not being aware of water temperatures being below 40 or exceeded 49 degrees (C), resulting in no immediate action taken to reduce water temperature exceeding 49 degrees (C). Interviews with PSWs #102, #103, and #109 confirmed the PSWs were not aware of what the minimum and maximum hot water temperatures should be in resident tubs/shower areas, thus the licensee procedures for water temperatures were not implemented. [s. 90. (2) (g)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 ensuring that the temperature of the water serving all bathtubs, showers, hand basins used by residents does not exceed 49 degrees Celsius; ensuring that immediate action was taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius and also ensuring that, the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Related to Log # 000398-18 involving resident #005:

A Critical Incident Report (CIR) was submitted to the Director for an environmental hazard incident that occurred on an identified date in January 2018. The CIR indicated at an identified time, the RN #102 reported to the on-call manager that the lights were not working in an identified resident's room. There was no indication in the CIR regarding heating malfunctioning in the same resident room. The RN indicated it did not interfere

with the care being provided to the resident and alternate lighting was provided.

The identified resident's room had two residents residing in the room, resident #005 and resident #002 . Resident #002 was cognitively impaired, but the resident family member was notified of the lighting and heating system malfunctioning.

During an interview with resident #005 and the resident family member indicated the resident had no recollection of the lights or heating not functioning in the resident's room. The family member also indicated not being aware that the lighting and heating malfunctioning in the residents room on an identified date in January 2018.

During an interview, PSW #103 indicated that at the time the incident occurred in the identified resident's room, the room was observed to be cold. The PSW indicated both the heating and lighting had malfunctioned. The PSW also indicated that this was reported to the RN #102, and the PSW provided the residents with extra blankets, a portable heater and a lamp overnight.

During an interview, RN #102 indicated becoming aware of the lighting and heating in the identified resident's room had malfunctioned and reported this to the on-call manager (DOC). The RN indicated that the light and heating system that had malfunctioned was not reported to resident #005's family member.

During an interview, the ED indicated that if the lighting and heating system had malfunctioned in a resident’s room, the expectation was that the resident and the resident's family member were notified.

Resident #005's family member was not given an opportunity to participate fully in the development and implementation of the resident’s plan of care, specifically related to when the lighting and heating systems in resident #005's room malfunctioned on an identified date in January 2018. [s. 6. (5)]

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 ensuring that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 92. Designated lead — housekeeping, laundry, maintenance

Specifically failed to comply with the following:

s. 92. (2) The designated lead must have,
(a) a post-secondary degree or diploma; O. Reg. 79/10, s. 92 (2).
(b) knowledge of evidence-based practices and, if there are none, prevailing practices relating to housekeeping, laundry and maintenance, as applicable; and O. Reg. 79/10, s. 92 (2).
(c) a minimum of two years experience in a managerial or supervisory capacity. O. Reg. 79/10, s. 92 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the designated lead for housekeeping, laundry, and maintenance had a post-secondary degree or diploma.

During an interview, the ESM #107 indicated being the designated lead for the Housekeeping, Laundry and Maintenance Departments. The ESM was recently hired at the LongTerm Care home, but did not have a diploma or a degree.

During an interview, the ED indicated that ESMs are hired through an external contracted services. The ED indicated that this contracted service is organized through the corporate head office.

Interview with ESM #107 and ED confirmed the designated lead for housekeeping, laundry, and maintenance did not have a post-secondary degree or diploma. [s. 92. (2)]

WN #5: 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):
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).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of 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, no later than one business day after the occurrence of the incident.

Related to Log # 000398-18 involving resident #005:

A Critical Incident Report (CIR) was submitted to the Director for an environmental hazard incident that occurred on an identified date in January 2018.

During interviews, PSW #103 and RN #102 confirmed the incident related to the heating and lighting systems in the identified resident's room malfunctioning, occurred on an identified date in January 2018.

During an interview with the DOC, indicated the Director was not informed of the environmental hazard incident related to the heating and lighting systems malfunctioning in an identified resident's room occurred on an identified date in January 2018, until two days later. The DOC indicated not being aware that the incident had to be reported, until was directed by the Corporate office. [s. 107. (3) 2.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (8) The licensee shall keep current all arrangements with community agencies, partner facilities and resources that will be involved in responding to emergencies. O. Reg. 79/10, s. 230 (8).

Findings/Faits saillants :

1. The licensee failed to ensure that all arrangements with community agencies, partner facilities and resources that will be involved in responding to emergencies is kept current.

Related to Logs #000277-18, #000398-18 and #000666-18:

There were two CIR submitted to the Director for environmental hazard incidents. An anonymous complaint was also received related to an environmental hazard.

A review of the Long Term Care Emergency plan had no documented evidence of current arrangements with community agencies, partner facilities and resources that would be involved in responding to emergencies.

During an interview, the ED indicated, the ED was still waiting for letters from the various community agencies that would be involved in responding to emergencies, in order to update the Emergency plan. [s. 230. (8)]

Issued on this 20th day of February, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIET MANDERSON-GRAY (607)
Inspection No. / No de l'inspection :	2018_687607_0001
Log No. / No de registre :	000277-18, 000398-18, 000630-18, 000666-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 8, 2018
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4
LTC Home / Foyer de SLD :	ReachView Village 130 Reach Street, UXBRIDGE, ON, L9P-1L3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Andrea DeLuca

To Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee shall ensure

1. A process is developed and put in place whereby the Environmental Service Manager, the Director of Care and or delegates are reviewing all documentation of air temperatures within the home by registered staff at-least daily to ensure timely action is taken by staff and members of the management team when air temperatures are below 22 degrees Celsius.

2. A process is developed a put in place for increase monitoring of air temperatures within the home during periods of extreme weather. The process should include all areas occupied or used by residents.

Grounds / Motifs :

1. The licensee has failed to ensure that the temperature in the home was maintained at a minimum of 22 degrees Celsius (C).

Related to Log # 000630-18:

An anonymous complaint was submitted to the Director, indicating that the heat system in the Long-Term Care home was not functioning well, several resident rooms were cold measuring 15 (C) and there had been a few pipes that had burst. Residents were complaining about how cold it was in the home and nothing was being done.

A review of the Air Temperature and Humidity Logs directs:
Air temperature to be maintained at a minimum of 22 degrees.
Immediate action to be taken if temperatures exceeded parameters - Notify the

Environmental or Manager on call. Do not continue baths until rectified.

A review of the Air Temperature and Humidity Logs indicated that there were five days in December 2017, and six days on eight different shifts in January in 2018, where the air temperatures were noted to be below 22 degrees (C).
The Air Temperature and Humidity Logs indicated the air temperatures in residents rooms were only monitored twice in December 2017, and was not monitored on identified dates in January 2018, despite resident complaints that the home was cold.

On an identified date and times in 2018, the Inspector observed the following air temperatures to be below 22 degrees (C):
- The thermostat located in an identified resident's room indicated the room temperature was 21 degrees (C). There were two residents that resided in the room at the time.
- In a second identified resident's room, noted cold air drafts felt coming from the closed window. A blanket was observed along the base of the window sill. There were two residents residing in the room at the time. Room temperature was 21 degrees (C).
- In a third identified resident's room, noted cold air drafts felt coming from the closed window. The room temperature was 19 (C).Transparent tape was observed around the entire parameter of the window where draft was felt as well as blanket along the base of the window sill.

On an identified date and time, the Inspector observed the ESM #107 applying weather strips to the windows in an identified resident's room

During an interview with resident #003, indicated that it was cold in the residents room and the building for about two weeks in December 2017, and the first week in January 2018. Resident #003 indicated complaining to staff and management and nothing was done. Resident #003 indicated that extra blankets was not given. The resident also indicated the heat was turned up on an identified date in 2018, when the Inspector arrived.

During an interview with resident #012 on an identified date, indicated it was cold for about two weeks in the month of December 2017, and the first week in January 2018. The resident indicated having to ring the call bell to ask staff for extra blankets.

During interviews, residents #006, #007, #008, and #011, indicated that it was cold in their rooms at times, as cold air draft came through the windows even though they were closed. Resident #008 also indicated that the latch on one of the window was broken causing cold air drafts.

During an interview, the ESM #107, indicated that the ESM had not had a chance to perform resident's room window audits in the home as they were too busy. The ESM also indicated not being aware that residents were complaining they were cold and if this was brought to the ESMs' attention the issue would have been addressed. The Inspector provided the ESM the list of rooms that was noted to have cold drafts coming from the windows. The ESM indicated that the window in resident room #017 did not need sealing with weather stripping as a family had already sealed the windows. The ESM indicated the family member had purchased the wrong weather strips for the window.

During an interview, the ED indicated that the previous ESM was responsible for maintaining the components of the windows. The ED further indicated there were no resident room audits completed since the residents of the home complained that they were cold.

The licensee does not have a history of non-compliance with Ontario Regulation (O. Reg.) 79/10, s. 21, however, there was potential for harm related to air temperatures, as evidenced that there was an anonymous complaint submitted to the Director related the home being cold and residents were complaining. During the inspection, interviews with several residents identified the same. Review of the air temperature logs completed in the home and direct observations of air temperature in residents rooms by the Inspector, confirmed the air temperatures were not maintained at a minimum temperature of 22 degrees (C), despite ongoing resident complaints regarding cold air temperature. Based on the severity and scope a Compliance Order was warranted. (607)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 16, 2018

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(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;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The Licensee is ordered to develop and implement a monitoring process supported by appropriate documentation to ensure immediate action is taken to reduce the temperature of the water serving all bathtubs, showers and hand basins used by residents in the event that it is below or exceeds 49 degrees Celsius.

Grounds / Motifs :

1. The licensee failed to ensure that the policy and procedures for water temperatures related to the water serving all bathtubs, showers, and hand basins used by residents, includes temperatures that does not exceed 49 degrees Celsius (C) and the temperature of the hot water serving all bathtubs and showers used by residents was maintained at a temperature of at least 40 degrees Celsius, was implemented.

Related to Log # 000277-18 and #000666-18:

Two Critical Incident Reports (CIR) were submitted to the Director on two identified dates, for environmental hazards. The first CIR indicated there was a leaking water pipe in the ceiling and the water was shut off for 1.5 hours. The second CIR was a water leak in a communal washroom and the water was shut off for less than six hours.

A review of the home's policy titled Care, policy # Care 14-010.02, (page 1 of 5) directs:
- Safe water temperature for staff assisted bath and shower is 38 degrees - 43 degrees Celsius.
- A daily water temperature check is performed and recorded before each first bath of the day.
- At a minimum three (3) water temperature checks carried out before immersing a resident into the tub or shower.
- The bath/shower Water Temperature Log will be used to record all water temperature.
- Water temperature checks that are outside the safe water temperature range will be reported immediately to the manager and maintenance. The identified tub or shower will be tagged out of service.

During an interview, PSW #103 indicated that water temperatures were monitored in the tub/baths areas prior to a resident bath. PSW further indicated the tub in each bath area has a sensor that would indicate how hot or cold the

water temperature was. The PSW also indicated that documentation was completed of the water temperatures of the residents' tubs on log/sheet located in the tub rooms. The PSW indicated that if the water temperature in the tub was over 40 degrees (C), it would be too hot for the residents. The PSW also indicated that a water temperature of 32 degrees (C) or lower would be too cold for the residents. The PSW further indicated if the water temperature was below 32 degrees (C), this would be communicated to the charge nurse on the unit, and if water temperature was above 40 degrees (C), the PSW can adjust the temperature of water using the tap that was located by the tub.

During an interview, PSW #102 indicated a thermometer located by the residents' bath tubs was used to monitor water temperatures every time they completed a bath for the residents. PSW #102 also indicated these temperatures were being recorded on a log located in the bath/shower room. The PSW also indicated that a temperature of 38.7 degrees (C) was a normal temperature for the residents, and indicated water temperatures above 38.7 degrees (C) would be too hot for the residents. PSW #102 also indicated that if the temperature was above 38.7 degrees (C) that they would not use the bathtub for residents' baths.

During an interview, PSW #109 indicated that prior to residents taking a bath/shower, water temperatures were being monitored in bathtubs, and once temperatures were taken they were logged on a sheet located in the bath area. The PSW indicated that if the water was not suitable for the residents, then the residents were bathed in another home area.

A review of the hot water temperatures monitored in the shower/tub areas for each unit that were below a minimum of 40 degrees (C) in January in 2018, indicated the following:

-Cedar Grove unit: on five identified dates in January 2018 the temperatures logged were: first date: 36.5, 39.1, 38.4 and 38.7 degrees (C); second date: 34.12 and 34.12 degrees (C); third date: 38.2, 38.1, 38.1 and 37.8 degrees (C); fourth date: 38.1 degrees (C); fifth date: 35.5, 34.0, 33.32, 37.2, 39.6 and 32.9, degrees (C). There were no documented hot water temperatures indicated for three identified dates in January 2018 prior to the inspection.

-Cardinal Court Unit: on two identified dates in January 2018 the temperatures logged were: first date: 37.3, 37.0, 37.8; 37.6 X 2, 37.3, 36.3 X 2, 37.6 and 37.5

degrees (C); second date: 34.8; 38.1; 37.5 x 2; 39, 34.1, 37.1 and 30.4 degrees (C). There were no documented hot water temperatures indicated for nine identified dates in January 2018.

-Blue Jay Boulevard Unit: On three identified dates in January 2018 the temperatures logged were: first date: 30 degrees (C) x 2, 31 and 30 degrees (C) x 3, 36.6 and 37.8 degree (C). There were no documented hot water temperatures indicated for five identified dates in January 2018.

-Spruce Unit: on two identified dates in January 2018 the temperatures logged were: first date: 39.5 and 35.8 degrees (C); and the second date: 38.0 and 37.0 degree (C). There were no documented hot water temperatures on nine identified dates in January 2018. This unit has two tubs but only one log was provided for the tub area and it was unclear which tub the water temperatures were monitored for.

2. A review of the Bath/Shower Water Temperature Logs indicated the following procedures: minimum temperature of resident water is 40 degrees Celsius and maximum temperature is to be 49 degrees Celsius. Immediate action to be taken if water temperatures exceed parameters: notify the Environmental or Manager on call. Do not continue baths until rectified.

The water temperature logs for December 2017 and January 2018, were reviewed and the following hot water temperatures in resident sinks were noted to exceed the water temperature parameters:

In 22 resident's room sinks the temperatures were as follows: 49.8 degrees (C); 61.5 degrees (C); 52.3 degrees (C); 56.1 degrees (C); 49.8 degrees (C); 55.6 degrees (C); 51.2 degrees; 49.9 degrees (C); 49.8 degrees (C); 55.8 degrees (C); 50.1 degrees (C); 49.6 degrees (C); 50. 3 degrees (C); 50.3 degrees (C); 49.6 degrees (C); 58.1 degrees (C); 49.5 degrees (C); 49.2 degrees (C); 54.1 degrees (C); 49.1 degrees (C); 49.1 degrees (C); and 50.2 degrees (C).

In 10 resident's communal washroom sinks the temperatures were as follows: 52.9 degrees (C); 49.3 degrees (C); 61.3 degrees (C) x 2; 56.8 degrees (C); 49.2 degrees (C); 49.3 degrees (C); 52.6 degrees (C); 55.6 degrees (C); and 63.8 degrees (C).

On an identified date in January 2018, the Inspector monitored water

temperatures and calibrated the thermometer used by the home to monitor water temperatures to be at 0.0 degrees (C) when placed in a glass of cold water for five minutes. The following areas were noted to have hot water temperatures that exceeded 49 degrees (C):

- On the Blue Jay unit, a resident communal washroom sink (where one of the pipes was leaking), the water temperature was 51.3 degrees (C).
- On the Cedar Grove unit, a resident communal washroom sink, the water temperature was 60 degrees (C).
- On the Cardinal Court unit, a resident tub, the water temperature was 52 .8 degrees (C).

During an interview, RN #102 and #108 who worked on two identified shifts indicated that whenever the water temperature exceeded 49 degrees or was below 40 degrees (C) in residents home areas, they would notify the Environmental Service Manger (ESM) or a Manager on call, and indicated the water temperatures that had exceeded 49 degrees (C) was reported to the ESM who previously worked at the home.

During an interview with the Executive Director (ED) indicated the Environmental Service Manager #112 would have been notified of the above water temperatures that exceeded 49 or were below 40 degrees (C). The ED indicated ESM #112 was no longer working at the home. The ED also indicated that ESM #106 was covering after ESM #112 left the home. The ED further indicated not being sure of what actions were taken by the ESMs at the time staff reported the water temperatures that were below or exceeded the parameters. During further interview, the ED indicated that the expectation was that staff notified the ESMs whenever water temperatures exceeded 49 or were below 40 degrees (C), and that the ESM should have taken appropriate action. The ED also indicated that if the tub or sink water was too hot or too cold, the PSWs were to report this to the RN. The RN would report this to the ESM, and the ESM would then check the source and take appropriate action. The ED further indicated that if the ESM was not on site, then the staff were to contact the ESM by phone for further directions.

During an interview, the ESM #106 who was covering the home after ESM #112 left, indicated that no one had notified ESM #106 of water temperatures in resident home areas that had exceeded 49 or were below 40 degrees (C) in the month of December 2017 or January 2018. During the same interview, the ESM

Manager #107, indicated being recently hired at the home. During interviews with ESM #106 and #107, both indicated that at present, there was a problem with the mixing valve being stuck at 43 degrees (C) and should have been reading between 40 and 50 degrees (C) when in normal operation. Both ESMs indicated, the valve being stuck at 43 degrees (C) would have affected current water temperatures in the home. They both indicated that if the resident's area water temperature was above 60 degrees (C) they would have someone come in to repair the valve immediately. The ESMs further indicated that they were not aware of water temperatures being above or below the required parameters, as no staff at the home had contacted them regarding this issue.

The licensee does not have a compliance history of non-compliance with Ontario Regulation (O. Reg.) 79/10, s. 90, however, there was potential for harm related to water temperatures, as evidenced by the home submitted two Critical Incident Reports related to environmental hazards and pipes leaking to the Director. A review of the Bath/Shower Temperature logs completed in the home and direct observations of water temperatures in residents bath/shower areas by the Inspector, confirmed the water temperatures were not maintained at a minimum temperature of 40 degrees (C), or had exceeded 49 degrees (C). Interviews with ESM #106 and #107 indicated not being aware of water temperatures being maintained at a minimum of 40 or exceeded 49 degrees (C), resulting in no immediate action taken to reduce water temperature exceeding 49 degrees (C) and this was widespread across the home. Interviews with PSWs #102, #103 and #109 confirmed the PSWs were not aware of what the minimum and maximum hot water temperatures should be in resident tubs/shower areas, thus the licensee procedures for water temperatures were not implemented. Based on the scope and severity a compliance order was warranted. (607)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 16, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 8th day of February, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector / Nom de l'inspecteur : Juliet Manderson-Gray

Service Area Office / Bureau régional de services : Ottawa Service Area Office