Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 8, 2019	2019_541169_0017	021792-18	Complaint

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

The Village of Wentworth Heights
1620 Upper Wentworth Street HAMILTON ON L9B 2W3

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

YVONNE WALTON (169)

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): August 1 and 2, 2019.

The following complaint was completed during the inspection related to falls management and continence Log# 021792-18.

During the inspection, the inspector observed care areas, reviewed clinical records and reviewed administrative notes.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), registered nursing staff, residents and families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. 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,
(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).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that the temperature of the water serving all bathtubs, showers and hand basins used by residents was 49 degrees Celsius or less.

On August 1, 2019, at 1030 hours, the hot water at the public washroom basin was noted to be 53.2 C. The washroom door was ajar and resident accessible. There were several residents observed in the vicinity of this washroom.

A public washroom basin had a water temperature of 58.3 degrees Celsius at 1035 hours. The washroom door was ajar and was resident accessible.

A public washroom basin had a water temperature of 54 degrees Celsius at 1045 hours. The washroom door was unlocked but closed and was resident accessible.

Interview with the Administrator on August 1, 2019, revealed there was a broken part on the hot water tank and the maintenance services were fixing it.
A review of the audits received from the Administrator for the month of July 2019, revealed temperatures were documented daily on each shift (various home areas, tub rooms, common areas and resident rooms) with temperatures below 40 degrees Celsius. The documentation did not identify any follow-up by the nursing staff to address the low temperatures.
An interview with the DOC confirmed the registered nursing staff take water temperatures at random areas of the home every shift.

On August 2, 2019, the Administrator confirmed the broken part on the hot water tank was repaired. Follow up temperatures were taken and noted to be below 49 degrees Celsius except for the public washroom by the DOC office which was identified as 51.6 degrees Celsius.
The thermometer used by the registered nursing staff was obtained by the DOC. The inspector and DOC verified the same public washroom basin temperature on a home area. There was a significant discrepancy between the two temperatures, from the same tap. The Administrator and DOC confirmed the thermometer was broken. [s. 90. (2) (h)]
The licensee failed to ensure procedures were developed and implemented to ensure that the temperature of the water serving all hand basins used by residents are 49 degrees Celsius or less.

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 that ensures procedures are developed and implemented to ensure that the temperature of the water serving all bathtubs, showers and hand basins used by residents are 49 degrees Celsius or less, to be implemented voluntarily.

Issued on this 14th day of August, 2019

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

Original report signed by the inspector.