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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 13, 2018	2018_539120_0007	025284-17	Follow up

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

Chartwell Willowgrove Long Term Care Residence
1217 Old Mohawk Road ANCASTER ON L9K 1P6

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

BERNADETTE SUSNIK (120)

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): February 8, 2018

An inspection (2017-689586-0003) was previously conducted September 12-25, 2017, subsequently followed by the issuance of an order related to the resident-staff communication and response system. For this follow-up visit, the conditions that were laid out in the order were met.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Environmental Services Supervisor, personal support workers and registered staff.

During the course of the inspection, the inspector randomly tested pagers carried by staff, reviewed eduction materials regarding the use of pagers, staff attendance records for education related to pager use, audit records for the resident-staff communication and response system, audit records for staff handling of pagers, maintenance logs, took water temperatures, reviewed water temperature logs, verified accuracy of probe thermometers used by staff in the home to take water temperatures and reviewed policies and procedures related to the hot water monitoring program and the monitoring of the resident-staff communication and response system.

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

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)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 17. (1)	CO #002	2017_689586_0003	120

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. 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).

Findings/Faits saillants :

1. The licensee did not ensure that procedures were 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.

The licensee's policy LTC-CA-WQ-200-07-06, titled "Hot Water Temperatures", dated December 2017, was developed to provide direction to maintenance and nursing staff in monitoring their water temperatures and how to report and take immediate action should water temperatures rise above 49 degrees Celsius (C). The direction for registered staff, should hot water exceed 49C, was to inform the Environmental Services Supervisor (ESS) immediately, post a warning, inform staff and residents, take additional hot water temperatures in other locations and document all action taken on the hot water temperature form. For the ESS, they were to investigate the reason for the hot water exceedances, record the hot water temperature at the source and to notify the Administrator. The Director of Regional Operations and Environmental Services Consultant would be contacted of ongoing concerns related to water.

The licensee's domestic hot water system was equipped with a device (mixing valve), that was inaccessible to residents and was required to regulate the temperature of the hot water. However, on multiple occasions in January 2018, the device did not appear to be regulating the water, as the water temperature was recorded to be over 49C. According to service records, the mixing valve was repaired on March 8, 2017, and was tested for proper function on April 7, 2017. The service report included notations that the water was "hot" on the east side and "moderately warm" on the west side of the building. No specific temperatures were included. The temperature at the mixing valve was

documented between 120-125 degrees Farenheit (F) or 49-51.6C. The ESS was not able to recall why the contractor returned in April 2017, whether the visit was a routine follow up visit after a repair or if the contractor was called in related to fluctuating water temperatures.

Registered staff (either a Registered Nurse or Registered Practical Nurse), one for each floor, were given the task to take hot water temperatures at resident accessible hand basins in each home area using a digital probe thermometer. The probe thermometers had not been verified for accuracy through a calibration process by either the first or second floor registered nursing staff. During the inspection, in the presence of the ESS, the two thermometers used were verified for accuracy by using ice water. The second floor thermometer was out of range by several degrees. The first floor thermometer was more accurate, and out by less than one degree. Therefore, only the first floor water temperature records were reviewed. For the month of January 2018, the "water temperature record - 24 hours" included documented temperatures for the first floor for the following:

January 1, 2018 - 55.9C (day), 53.7C (evening)
January 2, 2018 - 50.6C (night)
January 3, 2018 - 52.0C (evening)
January 4, 2018 - 54.5C (day), 53.2C (evening)
January 5, 2018 - 52.3C (day), 51.9C (evening)
January 6, 2018 - 53.0C (day), 51.2C (evening), 50.1C (night)

For the above recordings, a notation was made by the RN in the "corrective action" column, that the information was transcribed into the maintenance book. No additional actions were recorded (whether additional temperatures were taken, hot water shut off at the affected sink, signage posted etc). Additional recordings of water temperatures above 49C were made on January 7, 15, 16, 19, 20, 21, 22, 23, 26, 28 and 31, 2018. No notes or "corrective actions" were documented on January 7, 15, 16 and 31, 2018. According to the registered staff on the first and second floors, the ESS was not always contacted, that hot water temperatures above 49C were recorded in the maintenance log only. When asked about weekends, the registered staff reported that there were no maintenance staff present on weekends. When asked what immediate action was taken each time, one registered staff member reported that personal support workers were informed. No documentation was made as to what other actions were taken to ensure that residents did not get scalded at the affected accessible sinks.

The maintenance logs were reviewed for four different home areas, and notations were made that hot water temperatures were high or the actual reading was included. For the Battlefield area, on Tuesday, January 23, 2018, the RN documented that the water temperature was high. The "water temperature log" included recorded water temperatures over 51C on all three shifts. On January 25, 2018, the ESS documented "Adjust at main". The ESS explained that the entry meant that he had adjusted the mixing valve at the main boiler on Thursday, January 25, 2018. No immediate action was documented and the response to lower the temperature of the water did not occur until two days after the incident. On January 26, 2018, the hot water temperature, even though the mixing valve was adjusted the day before, was recorded between 51.9C and 59.8C throughout the day in the same home area. The findings were recorded in the maintenance log, but no follow up response was included. The adjustment to the mixing valve did not resolve the excessive hot water temperatures. According to the ESS, the mixing valve was adjusted nine times in the month of January 2018 and twice between February 1 and 8, 2018, to try and bring hot water temperatures down below 49C. The ESS had not contacted a plumbing contractor prior to the inspection and had not informed the administrator of the on-going water temperature fluctuations. The constant adjustments made to the mixing valve did not resolve the issue and further actions to address the mixing valve were not made.

The ESS reported that he had reviewed all of the temperature logs and signed the "water temperature log - 24 hours" twice in a one month period. However, no signature for the ESS was found on the January temperature log for the first floor. The source water temperature logs were reviewed, and no temperatures were recorded for any weekend in January or February 2018. The ESS stated that he did not work on weekends.

The licensee's procedures were not implemented by staff to ensure that the temperature of the water serving all bathtubs, showers and hand basins used by residents was 49C or less. [s. 90. (2) (g)]

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

Issued on this 15th day of February, 2018

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

Original report signed by the inspector.