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 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
Dec 18, 2018	2018_414110_0014	015924-18, 016969-18, 024705-18	Complaint

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

The Willows Estate Nursing Home
13837 Yonge Street AURORA ON L4G 3G8

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

DIANE BROWN (110), BERNADETTE SUSNIK (120)

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): September 21, 24, 25, 26, 27, 28, 29, 2018. October 1, 5 and 10, 2018.

The following complaint logs were conducted during this inspection:
Log #015924-18- safe and secure environment, cooling requirements and lack of care.
Log #024705-18 safe and secure environment, dietary services, maintenance services.
Log #016969-18 -safe and secure environment, cooling requirements and lack of care.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Environmental Services Manager, Registered Dietitian, Food Service Manager, Activation Manager, Registered Nursing staff, Physiotherapist, Cooks, Housekeeping aides, Dietary aides, Personal Support Workers.

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

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **4 VPC(s)**
- **4 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 LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee failed to ensure that the home was a safe environment for its residents.

1. On an identified date, between an identified time period, and for several minutes, Inspector #120 observed that no staff were present in the Emerald dining room or the attached kitchenette next to the dining room. Two residents were seated at tables in the kitchenette and five others in the dining room. Various staff members were portering residents from their rooms to the dining room for lunch. On the stove, located in the kitchenette was a large pot of boiling chicken stew. According to the Activation Manager, a program included the assistance of residents to cut up vegetables and make chicken stock or stew with activation staff. The Activation Manager acknowledged that there should have been activation staff present at all times when the stove was on and a scalding or burning risk was present for residents.

2. On two identified dates Inspectors #110 and #120, observed uneven areas near the front of the home, towards the main entrance. The main path towards the front doors, which was slightly inclined, had a large crack running across the path in the concrete and the concrete was chipped. Near the front doors, on the west side of the doors, concrete slabs had shifted, creating a large gap and a trip hazard. An area was also identified where the drive way meets the entrance ramp. The area was observed as uneven with cracks measuring 5 ft x 3 ft. An interview with the physiotherapist, who participated in inspector #110's observation, confirmed the cracks required filling and could be unsafe if a resident was walking independently.

3. On an identified date, Inspector #120 observed a soiled utility room door to be ajar on the second floor at approximately 1230 hours. The door could not be closed when several attempts were made due to door hardware issues. Registered staff #122 was informed and asked how they would secure the disinfectant products within the room. Staff #122 removed the disinfectant sprays after they were not able to close the door. The maintenance person was informed and had the door repaired within 20 minutes. [s. 5.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to ensure that every window in the home that opens to the outdoors and was accessible to residents could not be opened more than 15 centimeters.

On an identified date, Inspector #120 observed and tested a window on the second floor near the elevator to be missing a device to prevent it from opening more than 15 centimeters. The window was large enough to allow a person to crawl through it onto a roof.

On an identified date, Inspector #120 observed that the large five foot high window in the hair salon was able to slide wide open with no device to restrict it from opening more than 15 centimeters. The hairstylist was asked if she left residents alone in the room at times and indicated they would when they went to get other residents from their rooms. On October 10, 2018, the door to the hair salon was observed to be wide open and no staff or residents were inside at approximately 1100 hours. [s. 16.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the hydration programs include the identification of any risks related to hydration.

Three complaints were received by The Ministry of Health and Long Term Care of the extreme heat in the home during identified days of the summer. Two complaints identified that on an identified date, resident #002 was sent to the hospital and treated for a change in condition related to the extreme heat in the home.

A telephone interview with the complainant revealed that they had arrived to the home the afternoon on an identified date. The complainant described the extreme heat in the home.

A record review of the identified hospital's Emergency Record (ER) and interview with RN #119 confirmed the ER treatment for the resident's change in condition and diagnosis.

A record review of resident #002's written plan of care identified the resident's daily fluid

needs at an identified milliliters (ml) per day.

A record review of the Dietary Report for daily fluids intake identified resident #002's fluid intake in an identified month to be below the identified milliliters (ml) on each day of the month. A review of the three previous months Dietary Reports identified the resident to regularly consumed well below the identified milliliters on each day.

A further record review and an interview with the RD revealed the process for the assessment of a resident's fluid intake. The RD stated the night registered staff were to review a resident's fluid intake and send a referral to the RD when the resident's intake was below 1500mls a day for 3 days. The RD confirmed that no referrals related to resident #002's fluid intake had been received.

The home's policy Policy entitled Hydration Status #OTP-HP-3.1. Effective Date July 2017 directed the registered staff to submit a referral to the registered dietitian based on the risk of dehydration and reduced intake.

An interview with RN #103 revealed that the registered staff were responsible to record a resident's fluid intake at meals and PSW staff were to record intake at nourishment times. The RN continued to state that the night shift registered staff reviewed the resident's fluid intake reports and placed a star or highlighted the resident's name who had consumed less than 1500mls in that day. The RN further stated that a referral was to be sent to the RD when a resident consumed less than 1500mls per day over 2-3 days. The RN was unaware of resident #002's calculated fluid needs identified in the written plan of care and upon a review of resident #002's fluid intake for an identified month identified 29 days when the resident's intake was below 1500mls and confirmed that no referrals had been sent to the RD.

Interviews with RN #119, RPN #106 and RPN #107 also shared that the night registered staff printed out a 24 hr fluid report that identified how much fluid each resident was consuming in a 24 hr period. The staff member stated that if any resident was below 1500mls that day the night staff would highlight their name and direct staff to encourage the resident to drink and pass the information along to the next shift. RN #119 revealed that if they knew a resident required a greater amount of fluid than 1500mls that they would monitor for that amount. The RN was unaware of resident #002's calculated fluid needs documented in the resident's written plan of care and upon reviewing an identified months daily fluid intake for resident #002 confirmed that a referral should have been sent to the RD.

The interview with RPN #107 revealed that the night nurse will send a referral to the RD when the resident's intake was less than 1500mls for three days stating they are the staff who are looking back at the resident's intake over time.

An interview with night shift registered nurse, RPN #110 confirmed that they reviewed the 24 hour fluid report and any resident consuming under 1100mls or 1200mls they highlighted and brought to the PSWs attention at shift report. The RPN confirmed that they had not been documenting in the resident's health record if they recommended to push fluids or other interventions and that the daily fluid sheets used to communicate identified residents to monitor were disposed of and not kept at the end of each day. The RPN revealed there were a number of frail, smaller residents in the home who would not be able to consume 1500 mls per day and was unaware of resident #002's daily fluid requirement. The RPN confirmed they had not been sending referrals to the RD when a resident's intake had been low for three consecutive days and was unaware that resident #002's fluid intake had been that low.

The licensee failed to ensure that the hydration program included the identification of any risks related to hydration as there was no monitoring of the home's policy to ensure the night registered staff was identifying residents consuming under 1500mls over three consecutive days and referring to the RD for further hydration assessment and interventions. [s. 68. (2) (b)]

2. This inspection protocol was initiated related to a complaint. As a result of non-compliance having been identified with resident #002, the sample size was expanded by two additional residents including resident #003 and #004.

A record review of resident #003's Daily Fluid Intake between an identified seven day period of time identified one day when the resident met their daily fluid needs.

A record review of resident #004's Daily Fluid Intake between an identified seven day period of time identified no days when the resident met their daily fluid needs.

The night shift RPN #110 confirmed that a referral had not been sent to the RD based on the resident #003 and #004 fluid intake and acknowledged that referrals should have been sent. [s. 68. (2) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a written hot weather related illness prevention and management plan for the home that met the needs of the residents was developed in accordance with prevailing practices and was implemented when required to address the adverse effects on residents related to heat.

Prevailing practices are generally accepted widespread practices which are used to make decisions. The Ministry of Health and Long Term Care developed a guidance document entitled "Guidelines for the Prevention and Management of Hot Weather Related Illness in Long Term Care Homes, 2012", which was shared with all Long Term Care Homes in 2012. The guidance document includes information with respect to monitoring the internal building environment when outdoor conditions exceed a temperature of 25 degrees Celsius (C) and interventions to reduce heat related illness and to reduce heat in the building when the Humidex reaches 30 [some discomfort will begin at this level]. The Humidex is an index number that is used to describe how the weather feels to the average person and is determined when the effect of heat and humidity are combined. This is to ensure that cooling systems or other cooling alternatives in the building are functional and able to provide relief to residents in certain designated areas should they require it. The guidance document also includes information with respect to enhanced resident symptom monitoring related to excessive heat.

Heat warnings were issued for the Province of Ontario, including York Region, beginning on June 17, 2018, when the Humidex approached or exceeded 40. Values over a Humidex of 35 were experienced on June 17, 18, 29, 30, July 1-5, 2018, at which time designated cooling areas capable of holding up to 40 residents, which include dining rooms and common spaces, must be available to residents if a home's central air conditioning system is not adequate, functional or has not been provided.

A complaint was received on an identified date, that a resident's room on the second floor was very hot for five days during the identified heat warnings. No air conditioner was available in the resident's room and the room did not receive any tempered or cooled air, but was equipped with a portable fan. The resident was identified by registered staff to be at high risk for heat related symptoms and that they refused to leave their room. The resident fell several times in their room on an identified date during this time and was sent to hospital. Upon assessment at the hospital, the resident was deemed to have a heat related illness.

A second complaint was received at the end of another heat wave that began on an identified date. The complainant identified overly warm conditions in the home, lethargic residents and had concerns about a lack of air conditioning and overall ventilation. The complainant reported that they did not feel any difference in the temperature anywhere on the second floor and stated there was only a slight difference on the first floor within the smaller dining room.

During the inspection, the Administrator and Director of Care (DOC) provided a policy related to managing residents during hot weather, which was reviewed to determine compliance with this section. It was entitled "Prevention and Management of Hot Weather Related Illness" (CS-12.9) dated June 2018. No reference was made to the above noted Ministry guideline. The policy included symptoms and causes of heat related illness and that registered staff were responsible to direct and monitor resident care in accordance with the procedures outlined. The procedures were entitled "Prevention and Management of Hot Weather Related illness Multidisciplinary Responsibilities" (CS12.9(a)). It included various staff roles, responsibilities and interventions for residents. For maintenance staff, they were to monitor indoor temperatures, implement alternate methods for air cooling and implement strategies to maximize ventilation. For nursing staff, they were to identify residents at increased risk due to poor fluid intake, implement body cooling strategies and assess need for and provide additional fluids 24/7 based on identified need.

According to education and training records, the above noted policy and procedure was reviewed with 15 staff members on May 23, 2018. After the first complaint, the Administrator and DOC developed additional roles and responsibilities for all staff and the information was presented to all staff between July 13 and August 9, 2018. These additional roles included that nursing staff would take air temperatures on every shift, keep the windows and curtains closed, assess residents for signs and symptoms of dehydration, track residents who didn't want to leave their rooms and encourage residents to use cooler areas in the home such as "the lounge and dining rooms". Two PSWs #116 and #121 who were interviewed by Inspector #110 on September 25 and 26, 2018, reported that they did not feel that the training was adequate.

Based on the policies, procedures and added roles and responsibilities, the following remained unclear;

1. How the Humidex was calculated, what instruments were used to take air temperature and humidity readings and where the instruments were placed to get a representative reading.
2. How the instruments used to monitor air and humidity values were determined to be accurate.
3. The threshold Humidex (temperature and humidity combination) level that was used to alert staff to begin monitoring residents for heat related symptoms.
4. What alternate methods were available to cool the designated cooling areas should the existing air conditioners fail or where the existing units were not designed or capable of providing adequate cooling.
5. Where residents would be re-located to if the home could not offer adequate cooling anywhere withing the building (i.e. during a power failure)
6. Who was responsible for providing residents with fans or alternative cooling equipment.
7. What environmental controls could be implemented by the licensee to keep resident rooms cooler than the outdoors during extreme heat.

A tour of the home included a review of the designated cooling areas, the availability of fans, type of cooling equipment, type of window coverings and availability and functionality of mechanical ventilation systems.

The window coverings in resident rooms were observed to be thin, with light shining through the fabric. When closed against the heat of the sun, no relief from the heat was

felt. In dining rooms, corridor towards the dining rooms and the main sitting area in the foyer, the window coverings were made of shears. Therefore environmental strategies to keep heat out of the building were not implemented.

Ceiling fans and portable fans were noted in the halls and resident rooms. The licensee's policy did not include who received a fan, how to locate it within a room and who was responsible for providing the fans. The benefits of electric portable fans during extreme heat conditions [over 35C], is somewhat controversial for residents who have reduced sweating capabilities . Fans can actually increase the body's heat stress by blowing air that is warmer than the ideal body temperature over their skin which can speed heat-related illness, such as heat exhaustion and can cause dehydration and electrolyte imbalances if fluids and electrolytes are not replaced quickly enough. (JAMA 2015)

The home was not equipped with a centralized air conditioning system but was equipped with various models of stand-alone air conditioning units. Two dining rooms, both located on the first floor some distance away from the resident rooms, were each sized to accommodate approximately 40 residents each. These areas were therefore determined by the inspector to be the designated cooling areas. The larger dining room, labelled as the Sunshine dining room was over 1100 square feet with only one portable air conditioning unit in the window at one end of the dining room. The smaller dining room, labelled as the Emerald dining room had two air conditioning units, one in the window and one mounted on a wall. According to air temperature records maintained by registered staff, neither of the two areas were adequately cooler than the remainder of the first floor. The second floor did not include a cooling space that could accommodate 40 or more residents, but had a lounge area near the nurse's station with one ceiling mounted split heat and air conditioning unit on the north side of the hall and one portable window air conditioning unit on the south side of the hall. The first floor also had a similar set up as the second floor.

Both dining rooms and the second and first floor lounge areas were monitored by registered staff on a daily basis, once per shift throughout the summer months. According to Environment Canada's historical climate data for York Region between June 30 and July 5, 2018, the Humidex level outdoors was 29-46 between 0800 hours and 2100 hours. Humidex levels indoors will depend on what type of air cooling equipment was available. The temperature logs used by registered staff did not include an area in which to document the calculated Humidex level indoors. The air temperature logs kept by registered staff revealed only an air temperature and humidity level for the

first floor and air temperatures on the second floor. Registered staff documented that the air temperature on the second floor was 27C to 38C between June 30 and July 5, 2018. The accuracy of these values was in question, as some staff used an infrared thermometer to take the measurements and others used a wall mounted gauge near the nurse's station. A consistent approach using the same instrumentation was not evident.

The Emerald dining room was recorded to be in the range of 24-29C with a humidity of 37-64% [Humidex of 25-35] depending on the shift. The Sunshine dining room was similar, with a range of 24-28C with a humidity of 48-65%. Although the Humidex was lower inside than outside, the temperatures and humidity levels were not much different in the hallway, lounge, or front lobby and sitting area based on documented values.

During the inspection on October 10, 2018, when the outdoor temperature was 29C with a humidity of 49%, [Humidex of 34] the Sunshine dining room was measured using the inspector's hygrometer which was placed above the licensee's hygrometer at 1215 hours. The licensee's hygrometer was 23C and 65%. The Inspector's was 25C with a humidity of 60%. [Humidex of 30]. The accuracy of the licensee's hygrometer was in question and therefore the values collected over the summer months for the Sunshine dining room could not be relied upon. The hygrometer in the Emerald dining room at 0145 hours was 24C and 63%. The unit was determined to be accurate with the inspector's hygrometer.

Interview of RPN #106 by Inspector #110 was conducted on September 27, 2018, who stated that a cooling area was located on the 2nd floor but yet on an identified date, recorded that it was 38C at 1400 hours. The RPN confirmed using the temperature gauge that was on the wall at the nurse's station. The RPN also confirmed that they were required to take both humidity and temperature readings on both floors and did not know what the threshold level was before taking additional steps to manage resident comfort. The RPN acknowledged that no further action was taken when they identified 38C on the second floor on the identified date, and that some residents went downstairs. PSW #104 reported on September 26, 2018, that on the same identified date, they were not directed to take any residents down to the dining rooms but to keep them in the lounge on the second floor. The lounge was described to be very hot. PSW #114 reported on September 26, 2018, that it felt like it was 36C in the home on the second floor on the identified date.

The licensee therefore failed to ensure that a written hot weather related illness prevention and management plan for the home that met the needs of the residents was

developed in accordance with prevailing practices and was implemented when required to address the adverse effects on residents related to heat. [s. 20. (1)]

Additional Required Actions:

CO # - 004 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 , to be implemented voluntarily.

WN #5: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A complaint was received by the Ministry of Health and Long Term Care on an identified date that resident #001 had interventions that staff were not following and it was negatively affecting resident #001's health status.

An unannounced visit was made to the home at mealtime on an identified date. Resident #001 was identified in the dining room and observed. A record of what was offered to and taken by the resident was documented by Inspector #110.

A review of the resident's written plan of care identified the resident at nutritional risk and requiring dietary interventions.

A record review of a RD note on an identified date revealed that an identified visitor had spoken with the RD about the issue of staff not providing the resident with the required interventions and their concern regarding the impact to the resident's health status.

A record review of the progress notes identified on an identified documentation from the resident's attending physician stating that an identified individual was concerned about the resident's health status.

A further record review identified a register dietitian (RD) note weeks later. The documentation identified the identified visitor expressed the same concerns about the impact of staff not following interventions and the impact on resident #001's health status. The RD informed the identified visitor that the resident had interventions in place.

An interview with staff #112 after resident #001's meal observation on an identified date confirmed that resident #001 had individual interventions and should not have received four food items observed to be served to resident by inspector #110.

An interview with the RD confirmed that an identified laboratory marker of resident #001's health status had not been stable and that resident #001should not have been served the identified meal components served on the identified date. The RD confirmed that the dietary care set out in the resident's plan of care was not provided to resident #001 as specified in the plan. [s. 6. (7)]

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 the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care must be based on an interdisciplinary assessment of the resident's hydration status and any risks related to hydration.

Three complaints were received by The Ministry of Health and Long Term Care related to the extreme heat in the home during identified days of the summer. Two complaints identified that on an identified date, resident #002 was sent to the hospital and treated for a change in condition related to the extreme heat in the home.

A telephone interview with the complainant revealed that they had arrived to the home the afternoon of an identified date. The complainant described the extreme heat in the home.

A record review of the temperature logs identified that on an identified date, the lounge, considered the cooling area in an identified area, was 38C at an identified time. The temperature logs identified other identified areas were also at 38C. An interview with RPN #106, confirmed recording the air temperature on this day from a reading on the thermometer on the wall. An interview with PSW #114 who worked at an identified time on the same identified date revealed that the unit felt hot and described the temperature as 36C to 37C in areas on the unit.

A record review of the identified hospital's Emergency Record (ER) and interview with RN #119 confirmed the ER treatment for the resident's change in condition and diagnosis.

A record review of resident #002's most current Heat Assessment, identified the resident at high risk of heat related illness. Interventions were documented but did not include the identified risks as identified through staff interviews.

A record review of resident #002's written plan of care for hydration and eating identified the resident's level of mealtime assistance, dining location and their daily fluid needs in milliliters (ml).

A record review of the Dietary Report for daily fluids intake identified resident #002's fluid intake in an identified month to be below resident #002's established daily fluid needs in milliliters on each day of the month.

A review of the three previous months Dietary Reports identified the resident to regularly consume well below the established milliliters for each day.

An interview with PSW #116 revealed why resident #002 was at risk of heat related illness . PSW #121 revealed that it was warmer on the second floor with only limited air conditioning on the unit. The PSW also revealed that resident #002 was at risk of heat related illness with the same identified reasons. An interview with RN #103 revealed that resident #002 was a high risk for heat related illness and that the resident's written plan of care did not include the identified risks with interventions. The interview with RN #103 identified that the resident's plan of care did not include the risks related to resident #002's hydration. [s. 26. (3) 14.]

2. The licensee has failed to ensure that the registered dietitian who is a member of the staff of the home assess the resident's hydration status, and any risks related to hydration.

Three complaints were received by The Ministry of Health and Long Term Care related to the extreme heat in the home during identified days of the summer. Two complaints identified that on an identified date, resident #002 was sent to the hospital and treated for a change in condition related to the extreme heat in the home.

A record review of the identified hospital's Emergency Record (ER) and interview with RN #119 confirmed the ER treatment for resident #002's change in condition and diagnosis.

A record review of resident #002's written plan of care for hydration and eating identified the resident's level of meal time assistance, dining location and their daily fluid needs in millilitres per day.

Observations of resident #002 at mealtime were conducted on an identified date. On two identified occasions the resident was observed with food and drink present, no assistance and was not eating or drinking.

A record review of the Dietary Report for daily fluids intake identified resident #002's fluid intake in milliliters in an identified month to be below resident #002's established daily fluid needs on each day of the month. A review of the three previous months Dietary Reports identified the resident to regularly consume well below their established milliliters for each day.

A review of the OMNI Nutrition & Hydration Assessment form documented by the registered dietitian's (RD) on an identified date included resident #002's average fluid intake in milliliters over an identified period of time. The amount documented was below the residents individually calculated daily fluid needs. The form included documentation that at this time the RD will not make any changes to the resident's plan of care as nutrition interventions appear to be effective. The Assessment Form included a goal to maintain adequate hydration as indicated by meeting individually calculated fluid needs.

An interview with PSW #108 revealed resident #002's fluid likes and dislikes. An interview with the full time RPN #107 revealed the same fluid preferences and dislikes for resident #002.

An interview with the RD revealed that a resident was at high risk for dehydration if they were not consuming their required amount of fluid. The RD confirmed that resident #002's daily fluid requirement was an identified amount of mls, consistent with the written plan of care. The RD revealed that at the identified quarterly review they had documented that the resident had been meeting their fluid needs as they thought that staff were providing the resident with extra drinks which might not have been documented. The RD confirmed the resident's fluid intake was consistently below the resident's established fluid needs. The RD further revealed that they were unaware of any risks, fluid dislikes, related to the resident not achieving their estimated fluid requirement as was revealed through PSW interviews.

The RD failed to assess resident #002's risk to their hydration status when the resident continually failed to meet their estimated fluid requirement which was not further assessed. [s. 26. (4) (a),s. 26. (4) (b)]

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 the plan of care be based on an interdisciplinary assessment of the resident's hydration status and any risks related to hydration, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).

Findings/Faits saillants :

1. The licensee had failed to ensure there is an individualized menu developed for the resident if their needs cannot be met through the home's menu cycle.

A complaint was received by the Ministry of Health and Long Term Care log #024705-18, on an identified date that resident #001 had interventions that staff were not following and it was negatively affecting the resident's health status.

An unannounced visit was made to the home at mealtime on an identified date. Resident #001 was identified in the dining room and observed. A record of what was offered and taken by the resident was documented by Inspector #110.

A review of the resident's written plan of care identified the resident at nutritional risk and required dietary interventions.

A record review of a RD note on an identified date revealed that an identified visitor had spoken with the RD about the issue of staff not providing the resident with the required interventions and their concern regarding the impact to the resident's health status.

A review of the progress notes identified on an identified date documentation from the resident's attending physician stating that an identified individual was concerned about the resident's health status.

A further record review identified a register dietitian (RD) note weeks later. The documentation stated the identified visitor expressed the same concerns about the impact of staff not following interventions and the impact on resident #001's health status. The RD informed the identified visitor that the resident had interventions in place.

An interview with staff #112 after resident #001's meal observation on an identified date confirmed that resident #001 had individual interventions documented and should not have received four menu items observed to be served to the resident by inspector #110.

An interview with the RD confirmed that an identified laboratory marker of resident #001's health status had not been stable and that resident #001 should not have been served the identified meal components observed being served on the identified date. The RD identified that they had not created an individualized menu intervention as the Food Service Manager had not informed the RD of the newly implemented seasonal menu cycle.

An interview with full time cook #113 confirmed that there was an individualized menu for resident #001 for the previous menu cycle but since the implementation of the new menu

cycle, six weeks ago, there has not been a menu for resident #001.

An interview with the Food Service Manager confirmed there was no individualized menu in place for resident #001 whose needs can not be met through the home's menu cycle. [s. 71. (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 to ensure there is an individualized menu developed for the resident if their needs cannot be met through the home's menu cycle, to be implemented voluntarily.

WN #8: 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,
(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; O. Reg. 79/10, s. 90 (2).

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,
(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).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented to ensure that heating, ventilation and air conditioning systems were cleaned and in good repair and inspected at least every six months by a certified individual and that documentation was kept of the inspection.

On October 5, 2018, inspector #120 determined that the exhaust system was not operational in the home. The number, functionality, type or location of the home's mechanical exhaust systems and all fresh air make-up unit(s) could not be verified as the maintenance person or the Administrator were not fully knowledgeable. Documentation related to the systems, when inspected and by whom were requested.

On October 10, 2018, invoices were provided by the Administrator, however no work orders or service reports from the home's heating, ventilation and air conditioning (HVAC) technician for the spring start up inspection were included. An invoice dated October 9, 2018, was provided but it did not include any details about the service that

was performed at the home. No documentation was provided after requests were made of the Administrator on October 11 and 16, 2018, and after speaking with HVAC technician on October 17, 2018. The HVAC technician was also requested to provide their license number as proof that they were qualified to conduct the inspections.

On October 5, 2018, inspector #120 verified that the exhaust system servicing resident washrooms and the tub/shower rooms was not operational. The maintenance person for the home was informed that the exhaust system was not functional and after checking the roof top exhaust motor, confirmed that a component of the pulley was not working. The maintenance person adjusted the component and the exhaust was confirmed as operational on the same date. The maintenance person acknowledged that they did not check the exhaust system on a daily basis to ensure that it was functional at all times (as per O.Reg 79/10, s.90(3)).

According to the licensee's maintenance tasks and procedures, no daily responsibilities for the maintenance person were included related to checking mechanical ventilation systems on a daily basis. However, a monthly responsibilities checklist was included and required that the exhaust system be checked by the maintenance person. The completed form, when reviewed for September 2018, did not include the exact date when the exhaust system was inspected.

According to the HVAC technician on October 17, 2018, the first and second floor corridors [where resident rooms were located] were supplied with fresh air that was heated in the winter months, but not cooled in the summer months. According to RN #122, the air supply could be shut down when outdoor temperatures were too cold or too hot and a switch was located on the second floor near the ceiling. When observed on October 10, 2018, the switch was set to "winter mode". Therefore, the fresh air was supplied to the corridors only when heating was required based on a thermostatic setting. The older portion of the home [which included two dining rooms, hair salon and offices] was heated with either a hot air furnace system or hot water radiators and the rest of the home was heated with electric baseboard heaters. Two smaller ductless split units that could heat and cool were mounted on the ceiling on each floor near the nurse's stations. The technician confirmed that he had inspected all heating and cooling systems and that they were operational but could not provide a date or any documentation.

The larger dining room, which included hot water radiators, was observed to have three large square air supply vents located on the ceiling. No air was blowing down from the vents on either date of the inspection. The HVAC technician confirmed that the vents

were not connected to any heating or cooling equipment but may have been many years ago. The technician was informed that based on air temperatures and humidity levels taken on October 5, 2018, the space was very uncomfortable and not well ventilated without the additional air supply that may have been supplied to the dining room in the past.

According to the licensee's maintenance tasks and procedures, no information was included identifying that a qualified person was to inspect all heating, ventilation and air conditioning units at a minimum of twice per year and that documentation was to be kept of the inspection. The tasks and procedures included monthly responsibilities for in home maintenance staff to inspect the makeup air units and that in winter months, the maintenance person was to "make sure burners were operating and temperature was correct". The make-up air unit(s) were inspected by the maintenance person in September 2018, but no exact date was provided. The maintenance person acknowledged that mechanical systems were not checked daily to ensure they were functioning at all times. No other information was available about the home's mechanical ventilation systems [type, number and location] in the licensee's maintenance manual.

The licensee therefore failed to ensure that procedures were developed and implemented to ensure that the heating, ventilation and air conditioning systems were cleaned and in good repair and inspected at least every six months by a certified individual and that documentation was kept of the inspection. [s. 90. (2) (c)]

2. The licensee 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 did not exceed 49 degrees Celsius (C), and was controlled by a device, inaccessible to residents, that regulated the temperature.

The Administrator was not able to produce a procedure that addressed how the hot water system would be monitored, by whom and how often, what actions were necessary should hot water exceed 49C and whether the system was equipped with a device that regulated the hot water temperature.

On October 10, 2018, inspector #120 took the temperature of the hot water at a resident accessible sink in the Emerald dining room area. A calibrated probe thermometer designed for liquids was used. The hot water was allowed to run for several minutes until it settled at 54C. The maintenance person was informed immediately and stated that he would adjust the thermostat on the hot water holding tank. He reported that it was set at

approximately 130F or 55C. A tour of the mechanical room with the maintenance person revealed no mixing valve on the hot water line. The water temperature was regulated manually by the maintenance person by adjusting the thermostat.

According to water temperature logs maintained by registered staff, the hot water was recorded at 57C in the third identified room on October 7, 2018, 50C in an another identified room on September 22, 2018 and 58C in the third identified room on September 19, 2018.

The licensee therefore did not 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 did not exceed 49 degrees Celsius (C), and was controlled by a device, inaccessible to residents, that regulated the temperature. [s. 90. (2) (g)]

3. The licensee failed to ensure that procedures were developed and implemented to ensure that if the home was not using a computerized system to monitor the water temperature, the water temperature was monitored once per shift in random locations where residents had access to hot water.

The long term care home's hot water system was not on a computerized system to monitor the water temperatures and therefore staff of the home were required to monitor the temperatures. On October 10, 2018, inspector #120 reviewed the water temperature logs between September 9 and 24, 2018, maintained by the registered nurses on each floor. The log sheet included space to document hot water temperatures at random hand basins, the bathtub and shower on each of three shifts. For the 16 days in September 2018, the temperatures that were recorded in random resident accessible locations were all written in degrees Celsius. Some records included a duplication whereby the tub or shower temperature was documented twice. In addition, tub and shower rooms were not accessible to residents and were excluded from the evidence below. Other records included temperatures taken from sinks in the staff washroom or medication room, which were also excluded. No water temperatures were recorded on the following dates either on the first floor or on the second floor;

*evening shift on September 10
*day shift on September 11
*day shift on September 13
*day and night shift on September 14
*day, evening and night shifts on September 17

*evening shift on September 18
*evening shift on September 19
*night shift on September 20
*day shift on September 22
*day and evening shift on September 23
*day shift on September 24

The Administrator was not able to provide any procedures addressing how often the temperatures would be monitored, by whom, and how the water temperature would be measured. During the inspection, a registered staff member for each floor was asked about their measuring instruments. Registered staff #122 stated that sometimes, they used their infrared thermometer to take body temperatures but also had a probe thermometer. The probe was verified as accurate, however the infrared thermometer was not appropriate for liquids. Registered staff #107 produced a probe thermometer that was capable of reading only in Fahrenheit. When tested for accuracy, it was out of calibration by seven degrees Fahrenheit.

The licensee therefore failed to ensure that procedures were developed and implemented to ensure that if the home was not using a computerized system to monitor the water temperature, that the water temperature was monitored once per shift in random locations where residents had access to hot water. [s. 90. (2) (k)]

Issued on this 2nd day of January, 2019

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

Ministère 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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DIANE BROWN (110), BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2018_414110_0014
Log No. / No de registre :	015924-18, 016969-18, 024705-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 18, 2018
Licensee / Titulaire de permis :	0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership 2020 Fisher Drive, Suite 1, PETERBOROUGH, ON, K9J-6X6
LTC Home / Foyer de SLD :	The Willows Estate Nursing Home 13837 Yonge Street, AURORA, ON, L4G-3G8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Linda Burr

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

Ministère 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

To 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership, you are hereby required to comply with the following order(s) by the date (s) set out below:

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

Ministère 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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must be compliant with the LTCHA, 2007, s. 5.
The licensee must complete the following:
1. Develop a written protocol that identifies how the stove in the kitchenette, to which residents have access, will be used. The protocol shall include, at a minimum, how the stove and residents will be monitored to prevent resident scalding. The protocol shall be shared with all staff who use the stove with residents.
2. The concrete ramp at the front of the home shall be repaired at the base and at the midpoint to eliminate any uneven and loose surfaces.
3. The concrete pad (patio) located on the west side of the front door entrance shall be repaired to eliminate any uneven surfaces and large gaps.

Grounds / Motifs :

1. The licensee failed to ensure that the home was a safe environment for its residents.

1. On an identified date, between an identified time period, and for several minutes, Inspector #120 observed that no staff were present in the Emerald dining room or the attached kitchenette next to the dining room. Two residents were seated at tables in the kitchenette and five others in the dining room. Various staff members were portering residents from their rooms to the dining room for lunch. On the stove, located in the kitchenette was a large pot of boiling chicken stew. According to the Activation Manager, a program included the assistance of residents to cut up vegetables and make chicken stock or stew with activation staff. The Activation Manager acknowledged that there should have been activation staff present at all times when the stove was on and a scalding or burning risk was present for residents.

2. On two identified dates Inspectors #110 and #120, observed uneven areas near the front of the home, towards the main entrance. The main path towards the front doors, which was slightly inclined, had a large crack running across the path in the concrete and the concrete was chipped. Near the front doors, on the west side of the doors, concrete slabs had shifted, creating a large gap and a trip hazard. An area was also identified where the drive way meets the entrance ramp. The area was observed as uneven with cracks measuring 5 ft x 3 ft. An interview with the physiotherapist, who participated in inspector #110's observation, confirmed the cracks required filling and could be unsafe if a resident was walking independently.

3. On an identified date, Inspector #120 observed a soiled utility room door to be ajar on the second floor at approximately 1230 hours. The door could not be closed when several attempts were made due to door hardware issues. Registered staff #122 was informed and asked how they would secure the disinfectant products within the room. Staff #122 removed the disinfectant sprays after they were not able to close the door. The maintenance person was informed and had the door repaired within 20 minutes. [s. 5.]

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents.

The scope of the issue was a level 2, patterned.

A review of the home's compliance history revealed a level 4, ongoing non-compliance with a VPC or Order, as the home has had previous Compliance Order issued on November 23, 2017, in inspection report #2017_595604_0015.

(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 30, 2019

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

Ministère 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

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. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 16.
The licensee must complete the following:
1. Audit all windows to which residents have access to ensure that a device has been installed to limit the window opening to 15 centimeters or less.
2. Window limiting devices shall be of the type that cannot be easily manipulated, disengaged or removed by anyone other than maintenance staff.
3. Documentation shall be kept on the premises of the audit results. At a minimum the results shall include the name of the auditor, the date the windows were audited, the results of the audit and any follow up actions taken.
4. The licensee shall develop a schedule to have the windows audited at a minimum of yearly or more frequently depending on the type of window limiting devices installed.

Grounds / Motifs :

1. 1. The licensee failed to ensure that every window in the home that opens to the outdoors and was accessible to residents could not be opened more than 15 centimeters.

On an identified date, Inspector #120 observed and tested a window on the second floor near the elevator to be missing a device to prevent it from opening more than 15 centimeters. The window was large enough to allow a person to crawl through it onto a roof.

On an identified date, Inspector #120 observed that the large five foot high window in the hair salon was able to slide wide open with no device to restrict it from opening more than 15 centimeters. The hairstylist was asked if she left residents alone in the room at times and she said yes, when she went to get other residents from their rooms. On October 10, 2018, the door to the hair salon was observed to be wide open and no staff or residents were inside at approximately 1100 hours. [s. 16.]

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents.

The scope of the issue was a level 2, patterned.

A review of the home's compliance history revealed a level 4, ongoing non-compliance with a VPC or Order, as the home has had a Compliance Order issued under LTCHA, 2007, c. 8, s. 5 on November 23, 2017, inspection report # 2017_595604_0015, that included grounds related to O.Reg. 79/10. s 16. (120)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 25, 2019

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

Ministère 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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,

(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;

(b) the identification of any risks related to nutrition care and dietary services and hydration;

(c) the implementation of interventions to mitigate and manage those risks;

(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and

(e) a weight monitoring system to measure and record with respect to each resident,

(i) weight on admission and monthly thereafter, and

(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 68 (2)
Specifically, the licensee shall ensure that within one month of receipt of this order the licensee shall complete the following:

1. Identify all residents who have consumed under 1500mls or less than their fluid requirement over three consecutive days starting with the month of November 2018.

2. A meeting(s) shall be arranged with the interdisciplinary team, including the RD, to assess those identified resident's with reduced fluid intake.

3. All interventions, as assessed by the interdisciplinary team shall be identified on the resident's plan of care and implemented.

4. A review of each resident identified at hydration risk along with the care plan interventions will be shared at shift report for at minimum one month after completion of requirements #1 - #3.

5. Education shall be provided, with documented dates and staff attendance, to all nursing staff and personal support staff on the home's hydration monitoring policy.

6. A record is required to be kept by the licensee for all actions undertaken in steps 1 - 5 above.

Grounds / Motifs :

1. 1. The licensee failed to ensure the hydration programs include the identification of any risks related to hydration.

Three complaints were received by The Ministry of Health and Long Term Care of the extreme heat in the home during identified days of the summer. Two complaints identified that on an identified date, resident #002 was sent to the hospital and treated for a change in condition related to the extreme heat in the home.

A telephone interview with the complainant revealed that they had arrived to the home the afternoon on an identified date. The complainant described the

extreme heat in the home.

A record review of the identified hospital's Emergency Record (ER) and interview with RN #119 confirmed the ER treatment for the resident's change in condition and diagnosis.

A record review of resident #002's written plan of care identified the resident's daily fluid needs at an identified milliliters (ml) per day.

A record review of the Dietary Report for daily fluids intake identified resident #002's fluid intake in an identified month to be below the identified milliliters (ml) on each day of the month. A review of the three previous months Dietary Reports identified the resident to regularly consumed well below the identified milliliters on each day.

A further record review and an interview with the RD revealed the process for the assessment of a resident's fluid intake. The RD stated the night registered staff were to review a resident's fluid intake and send a referral to the RD when the resident's intake was below 1500mls a day for 3 days. The RD confirmed that no referrals related to resident #002's fluid intake had been received.

The home's policy Policy entitled Hydration Status #OTP-HP-3.1. Effective Date July 2017 directed the registered staff to submit a referral to the registered dietitian based on the risk of dehydration and reduced intake.

An interview with RN #103 revealed that the registered staff were responsible to record a resident's fluid intake at meals and PSW staff were to record intake at nourishment times. The RN continued to state that the night shift registered staff reviewed the resident's fluid intake reports and placed a star or highlighted the resident's name who had consumed less than 1500mls in that day. The RN further stated that a referral was to be sent to the RD when a resident consumed less than 1500mls per day over 2-3 days. The RN was unaware of resident #002's calculated fluid needs identified in the written plan of care and upon a review of resident #002's fluid intake for an identified month identified 29 days when the resident's intake was below 1500mls and confirmed that no referrals had been sent to the RD.

Interviews with RN #119, RPN #106 and RPN #107 also shared that the night registered staff printed out a 24 hr fluid report that identified how much fluid each resident was consuming in a 24 hr period. The staff member stated that if any resident was below 1500mls that day the night staff would highlight their name and direct staff to encourage the resident to drink and pass the information along to the next shift. RN #119 revealed that if they knew a resident required a greater amount of fluid than 1500mls that they would monitor for that amount. The RN was unaware of resident #002's calculated fluid needs documented in the resident's written plan of care and upon reviewing an identified months daily fluid intake for resident #002 confirmed that a referral should have been sent to the RD.

The interview with RPN #107 revealed that the night nurse will send a referral to the RD when the resident's intake was less than 1500mls for three days stating they are the staff who are looking back at the resident's intake over time.

An interview with night shift registered nurse, RPN #110 confirmed that they reviewed the 24 hour fluid report and any resident consuming under 1100mls or 1200mls they highlighted and brought to the PSWs attention at shift report. The RPN confirmed that they had not been documenting in the resident's health record if they recommended to push fluids or other interventions and that the daily fluid sheets used to communicate identified residents to monitor were disposed of and not kept at the end of each day. The RPN revealed there were a number of frail, smaller residents in the home who would not be able to consume 1500 mls per day and was unaware of resident #002's daily fluid requirement. The RPN confirmed they had not been sending referrals to the RD when a resident's intake had been low for three consecutive days and was unaware that resident #002's fluid intake had been that low.

The licensee failed to ensure that the hydration program included the identification of any risks related to hydration as there was no monitoring of the home's policy to ensure the night registered staff was identifying residents consuming under 1500mls over three consecutive days and referring to the RD for further hydration assessment and interventions. [s. 68. (2) (b)]

(110)

2. 2. This inspection protocol was initiated related to a complaint. As a result of non-compliance having been identified with resident #002, the sample size was expanded by two additional residents including resident #003 and #004.

A record review of resident #003's Daily Fluid Intake between an identified seven day period of time identified one day when the resident met their daily fluid needs.

A record review of resident #004's Daily Fluid Intake between an identified seven day period of time identified no days when the resident met their daily fluid needs.

The night shift RPN #110 confirmed that a referral had not been sent to the RD based on the resident #003 and #004 fluid intake and acknowledged that referrals should have been sent. [s. 68. (2) (b)]

The severity of this issue was determined to be a level 3 as there was actual harm/risk to resident #001.

The scope of the issue was a level 3 widespread as it related to all three of the residents reviewed.

The home had a level 2 compliance history as they had no non-compliance with this section of the regulation.

(110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2019

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

Ministère 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

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

Order / Ordre :

The licensee shall be compliant with s. 20(1) of O. Reg. 79/10.

Specifically, the licensee shall complete and implement the following:

Amend the policy entitled "Prevention and Management of Hot Weather Related Illness" (CS-12.9), dated June 2018 to include the following:

a) Where specifically in the home the designated cooling areas will be established and who will monitor the areas for air temperature and humidity and how often; and
b) How the Humidex will be calculated, what form will be used to document the values, what gauges or instruments will be used to take air temperature and humidity readings and where the instruments are to be placed to get a representative reading of the designated cooling area; and
c) How the instruments or gauges used to monitor air and humidity values will be regularly verified for accuracy; and
d) The threshold Humidex (temperature and humidity combination) level that will be used to alert staff to begin monitoring residents for heat related symptoms and to begin implementing appropriate interventions for each resident; and
e) What alternative strategies, equipment or methods are available to staff to cool the designated cooling areas should the existing air conditioners fail or are not capable of providing adequate cooling to the residents to relieve heat related symptoms; and
f) Where residents can be re-located to if the home cannot offer adequate cooling anywhere within the building (i.e. during a power failure); and
g) Who will be responsible for providing residents with fans or alternative cooling equipment if the resident or their substitute decision maker is not able to do so and how fans or alternative cooling equipment will be managed (cleaning, maintenance and whether appropriate for resident's health condition); and
h) Environmental strategies to reduce heat from gaining entry into the building.

Grounds / Motifs :

1. 1. The licensee failed to ensure that a written hot weather related illness prevention and management plan for the home that met the needs of the residents was developed in accordance with prevailing practices and was implemented when required to address the adverse effects on residents related to heat.

Prevailing practices are generally accepted widespread practices which are used to make decisions. The Ministry of Health and Long Term Care developed a guidance document entitled "Guidelines for the Prevention and Management of Hot Weather Related Illness in Long Term Care Homes, 2012", which was shared with all Long Term Care Homes in 2012. The guidance document includes information with respect to monitoring the internal building environment when outdoor conditions exceed a temperature of 25 degrees Celsius (C) and interventions to reduce heat related illness and to reduce heat in the building when the Humidex reaches 30 [some discomfort will begin at this level]. The Humidex is an index number that is used to describe how the weather feels to the average person and is determined when the effect of heat and humidity are combined. This is to ensure that cooling systems or other cooling alternatives in the building are functional and able to provide relief to residents in certain designated areas should they require it. The guidance document also includes information with respect to enhanced resident symptom monitoring related to excessive heat.

Heat warnings were issued for the Province of Ontario, including York Region, beginning on June 17, 2018, when the Humidex approached or exceeded 40. Values over a Humidex of 35 were experienced on June 17, 18, 29, 30, July 1-5, 2018, at which time designated cooling areas capable of holding up to 40 residents, which include dining rooms and common spaces, must be available to residents if a home's central air conditioning system is not adequate, functional or has not been provided.

A complaint was received on an identified date, that a resident's room on the second floor was very hot for five days during the identified heat warnings. No air conditioner was available in the resident's room and the room did not receive any tempered or cooled air, but was equipped with a portable fan. The resident was identified by registered staff to be at high risk for heat related symptoms and that they refused to leave their room. The resident fell several times in their room on an identified date during this time and was sent to hospital. Upon assessment at the hospital, the resident was deemed to have a heat related illness.

A second complaint was received at the end of another heat wave that began on an identified date. The complainant identified overly warm conditions in the

home, lethargic residents and had concerns about a lack of air conditioning and overall ventilation. The complainant reported that they did not feel any difference in the temperature anywhere on the second floor and stated there was only a slight difference on the first floor within the smaller dining room.

During the inspection, the Administrator and Director of Care (DOC) provided a policy related to managing residents during hot weather, which was reviewed to determine compliance with this section. It was entitled "Prevention and Management of Hot Weather Related Illness" (CS-12.9) dated June 2018. No reference was made to the above noted Ministry guideline. The policy included symptoms and causes of heat related illness and that registered staff were responsible to direct and monitor resident care in accordance with the procedures outlined. The procedures were entitled "Prevention and Management of Hot Weather Related illness Multidisciplinary Responsibilities" (CS12.9(a)). It included various staff roles, responsibilities and interventions for residents. For maintenance staff, they were to monitor indoor temperatures, implement alternate methods for air cooling and implement strategies to maximize ventilation. For nursing staff, they were to identify residents at increased risk due to poor fluid intake, implement body cooling strategies and assess need for and provide additional fluids 24/7 based on identified need.

According to education and training records, the above noted policy and procedure was reviewed with 15 staff members on May 23, 2018. After the first complaint, the Administrator and DOC developed additional roles and responsibilities for all staff and the information was presented to all staff between July 13 and August 9, 2018. These additional roles included that nursing staff would take air temperatures on every shift, keep the windows and curtains closed, assess residents for signs and symptoms of dehydration, track residents who didn't want to leave their rooms and encourage residents to use cooler areas in the home such as "the lounge and dining rooms". Two PSWs #116 and #121 who were interviewed by Inspector #110 on September 25 and 26, 2018, reported that they did not feel that the training was adequate.

Based on the policies, procedures and added roles and responsibilities, the following remained unclear;

1. How the Humidex was calculated, what instruments were used to take air

temperature and humidity readings and where the instruments were placed to get a representative reading.
2. How the instruments used to monitor air and humidity values were determined to be accurate.
3. The threshold Humidex (temperature and humidity combination) level that was used to alert staff to begin monitoring residents for heat related symptoms.
4. What alternate methods were available to cool the designated cooling areas should the existing air conditioners fail or where the existing units were not designed or capable of providing adequate cooling.
5. Where residents would be re-located to if the home could not offer adequate cooling anywhere withing the building (i.e. during a power failure)
6. Who was responsible for providing residents with fans or alternative cooling equipment.
7. What environmental controls could be implemented by the licensee to keep resident rooms cooler than the outdoors during extreme heat.

A tour of the home included a review of the designated cooling areas, the availability of fans, type of cooling equipment, type of window coverings and availability and functionality of mechanical ventilation systems.

The window coverings in resident rooms were observed to be thin, with light shining through the fabric. When closed against the heat of the sun, no relief from the heat was felt. In dining rooms, corridor towards the dining rooms and the main sitting area in the foyer, the window coverings were made of shears. Therefore environmental strategies to keep heat out of the building were not implemented.

Ceiling fans and portable fans were noted in the halls and resident rooms. The licensee's policy did not include who received a fan, how to locate it within a room and who was responsible for providing the fans. The benefits of electric portable fans during extreme heat conditions [over 35C], is somewhat controversial for residents who have reduced sweating capabilities . Fans can actually increase the body's heat stress by blowing air that is warmer than the ideal body temperature over their skin which can speed heat-related illness, such as heat exhaustion and can cause dehydration and electrolyte imbalances if fluids and electrolytes are not replaced quickly enough. (JAMA 2015)

The home was not equipped with a centralized air conditioning system but was equipped with various models of stand-alone air conditioning units. Two dining rooms, both located on the first floor some distance away from the resident rooms, were each sized to accommodate approximately 40 residents each. These areas were therefore determined by the inspector to be the designated cooling areas. The larger dining room, labelled as the Sunshine dining room was over 1100 square feet with only one portable air conditioning unit in the window at one end of the dining room. The smaller dining room, labelled as the Emerald dining room had two air conditioning units, one in the window and one mounted on a wall. According to air temperature records maintained by registered staff, neither of the two areas were adequately cooler than the remainder of the first floor. The second floor did not include a cooling space that could accommodate 40 or more residents, but had a lounge area near the nurse's station with one ceiling mounted split heat and air conditioning unit on the north side of the hall and one portable window air conditioning unit on the south side of the hall. The first floor also had a similar set up as the second floor.

Both dining rooms and the second and first floor lounge areas were monitored by registered staff on a daily basis, once per shift throughout the summer months. According to Environment Canada's historical climate data for York Region between June 30 and July 5, 2018, the Humidex level outdoors was 29-46 between 0800 hours and 2100 hours. Humidex levels indoors will depend on what type of air cooling equipment was available. The temperature logs used by registered staff did not include an area in which to document the calculated Humidex level indoors. The air temperature logs kept by registered staff revealed only an air temperature and humidity level for the first floor and air temperatures on the second floor. Registered staff documented that the air temperature on the second floor was 27C to 38C between June 30 and July 5, 2018. The accuracy of these values was in question, as some staff used an infrared thermometer to take the measurements and others used a wall mounted gauge near the nurse's station. A consistent approach using the same instrumentation was not evident.

The Emerald dining room was recorded to be in the range of 24-29C with a humidity of 37-64% [Humidex of 25-35] depending on the shift. The Sunshine dining room was similar, with a range of 24-28C with a humidity of 48-65%. Although the Humidex was lower inside than outside, the temperatures and

humidity levels were not much different in the hallway, lounge, or front lobby and sitting area based on documented values.

During the inspection on October 10, 2018, when the outdoor temperature was 29C with a humidity of 49%, [Humidex of 34] the Sunshine dining room was measured using the inspector's hygrometer which was placed above the licensee's hygrometer at 1215 hours. The licensee's hygrometer was 23C and 65%. The Inspector's was 25C with a humidity of 60%. [Humidex of 30]. The accuracy of the licensee's hygrometer was in question and therefore the values collected over the summer months for the Sunshine dining room could not be relied upon. The hygrometer in the Emerald dining room at 0145 hours was 24C and 63%. The unit was determined to be accurate with the inspector's hygrometer.

Interview of RPN #106 by Inspector #110 was conducted on September 27, 2018, who stated that a cooling area was located on the 2nd floor but yet on an identified date, recorded that it was 38C at 1400 hours. The RPN confirmed using the temperature gauge that was on the wall at the nurse's station. The RPN also confirmed that they were required to take both humidity and temperature readings on both floors and did not know what the threshold level was before taking additional steps to manage resident comfort. The RPN acknowledged that no further action was taken when they identified 38C on the second floor on the identified date, and that some residents went downstairs. PSW #104 reported on September 26, 2018, that on the same identified date, they were not directed to take any residents down to the dining rooms but to keep them in the lounge on the second floor. The lounge was described to be very hot. PSW #114 reported on September 26, 2018, that it felt like it was 36C in the home on the second floor on the identified date.

The licensee therefore failed to ensure that a written hot weather related illness prevention and management plan for the home that met the needs of the residents was developed in accordance with prevailing practices and was implemented when required to address the adverse effects on residents related to heat. [s. 20. (1)]

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents.

The scope of the issue was a level 3, widespread.

The home had a level 2 compliance history as they had no non-compliance with this section of the regulation.

(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 18, 2019

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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

Ministère 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

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 18th day of December, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DIANE BROWN

Service Area Office /
Bureau régional de services : Central East Service Area Office