Ontario

**Inspection Report Under the**
**Fixing Long-Term Care Act, 2021**

**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**Central West District**
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# Original Public Report

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| **Report Issue Date:** July 24, 2023 | |
| **Inspection Number:** 2023-1377-0004 | |
| **Inspection Type:**<br>Complaint | |
| **Licensee:** Extendicare (Canada) Inc. | |
| **Long Term Care Home and City:** Extendicare Halton Hills, Georgetown | |
| **Lead Inspector**<br>Bernadette Susnik (120) | **Inspector Digital Signature**<br>Bernadette Susnik Digitally signed by Bernadette Susnik Date: 2023.07.25 09:23:26 -04'00' |
| **Additional Inspector(s)** | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 22, 2023, and July 7, 2023
The inspection occurred offsite on the following date(s): June 23, 27, 2023 and July 11, 2023

The following intake(s) were inspected:

- Intake: #00085754 - IL-12149-CW Complaint regarding excessive heat in resident rooms and whether the resident rooms are served by air conditioning.

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

Resident Care and Support Services
Housekeeping, Laundry, and Maintenance Services
Safe and Secure Home

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Specific duties re cleanliness and repair

**NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 19 (2) (a)

The licensee has failed to ensure that the home was kept clean and sanitary.

**Rationale and Summary**

1. On July 7, 2023, four out of five spa rooms had accumulated black dirt build-up within the texturized flooring material in areas at doorways, around tubs and shower cabinets and in the washrooms in Belfountain and Ballinafad home areas. Heavy black stains (possibly manganese build up) were noted around standing water on the floor in the Glen Williams home area tub and shower rooms, and lighter black stains in the Terra Cotta home area tub and shower rooms where water had sat and then dried out. The floors were last deep cleaned using a floor machine on or about June 23, 2023, by the home's heavy-duty cleaner. According to housekeeping staff #105, the floors were not cleaned daily by housekeepers.

2. The carpets were heavily stained and worn in common areas and corridors in three home areas, where carpets were provided and on the main floor in all common areas. Cleaning staff were not provided with sufficient housekeeping equipment (as required under s. 93 (4) of O. Reg. 246/22) such as a carpet extractor for over a year. One was not provided until the inspection was initiated. No alternatives were implemented such as the services of a professional carpet cleaning company. Therefore, no routine carpet cleaning was in place.

3. The balconies, front sitting areas, courtyards, and gated back patio were not kept clean of debris. Leaves from the fall of 2022 were piled up around garden beds and in niches of the building. Sunflower seed shells, bird droppings, bird nesting materials and other debris was observed along the front side of the home. Green algae was adhered along the bottom of hand railings on balconies, black soot and dirt had accumulated on the siding and windows and window tracks were dirty (inside and out).

According to the housekeeping schedules and interview with the Environmental Services Manager, the licensee had a contract with an external contractor to provide three full-time housekeepers and one full-time heavy-duty cleaner for five home areas, common areas and staff spaces. The number of staff available was insufficient to ensure that contact surfaces and resident equipment in all five home areas

was cleaned at a frequency as identified in evidence-based practices for infection prevention and control. Staffing was insufficient to ensure that furnishings, general equipment, resident rooms, flooring, windows, wall surfaces, exterior areas and staff areas were cleaned at the frequency prescribed by the contractor's own tasks, schedules, and procedures.

Failure to ensure that the home was kept clean and sanitary may increase the potential for risks associated with infectious diseases and pest infestations.

**Sources:** Review of housekeeping job routines, housekeeping schedules, housekeeping audit (July 7, 2023), interview with housekeeping staff, Environmental Services Manager, observations.
[120]

## WRITTEN NOTIFICATION: Specific duties re cleanliness and repair

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)

The licensee has failed to ensure that the home and equipment were maintained in a safe condition and in a good state of repair.

**Rationale and Summary**

1. The shower area in the Glen Williams home area was being used by staff to shower residents even though the shower area was under renovation. The area was previously equipped with a seated shower cabinet which was positioned over a fixed drainage pipe. When removed, a section of pipe was left behind which was approximately an inch above the floor. Heavy amounts of pooling water were observed on the floor left over by care staff. The floor did not appear to be adequately sloped towards the one floor drain. The space was not secured to prevent staff and resident use until the renovation was fully completed.

2. Two mechanical tubs (Glen Williams and Belfountain home areas) were observed to be leaking water, both of which had “out of order” signs on them. The tub manufacturer’s service technician was on site on April 15, 2023 and identified that plumbing to turn off the water to the tub was ceased due to hard water scale formation on one tub, and parts were not readily available for another. The contractor identified that the tubs were beyond their life expectancy and advised that they be replaced. The home’s water supply has been identified as very high in minerals and a water softener was confirmed to service the kitchen and laundry areas only.

Both tub areas were accessible to staff on July 7, 2023, and pools of water were on the floor for both tub areas. None of the tubs in the home had a separate water shut-off valves, for situations when the shut-off at each tub was ceased or not functioning. Both tubs could be lowered and raised, despite the requirement by the manufacturer to turn off both the water and electrical supply to the tubs when they leaked water. Action to replace the tubs was not initiated until after the inspection.

3. While touring multiple flat roofs with the maintenance lead, large clumps of algae were seen growing on the aggregate. This occurs only when heavy amounts of water ponds on the roof and does not drain properly. Leaves were piled in several corners and metal debris not belonging to the roof top units were strewn all over multiple flat roofs. The maintenance person did not have any experience or training to visually inspect roofing systems for condition and had no procedures to guide them. The licensee did not have any records that a qualified contractor inspected all of the roofing systems on a routine basis. According to historical records, a roofing contractor was consulted for remedial purposes only, when leaks were identified by staff.

4. The laminated cabinetry in most tub and shower areas had damaged rough edges, with peeled laminate.

5. The laundry room had split flooring material in front of the washing machines. Staff #100 reported tripping over these tears. The flooring material in the Ballinafad tub area and in the Terra Cotta shower area were cracked or split open.

6. The exhaust system, when tested, did not appear to be functional (no suction) in the Wildwood shower room, Ballinafad tub room, Glen Williams washroom, shower, and tub rooms and Belfountain tub room. The issue was later deemed to have been related to a tripped breaker. The maintenance person was unaware of the issue and had not been oriented as to how to monitor for system function. Failure to ensure that the home and equipment are maintained in a safe condition and in a good state of repair increases the potential for injury to both staff and residents.

**Sources:** Observation, review of service reports from external contractor, interview with acting administrator, environmental services manager, and maintenance person.
[120]

## WRITTEN NOTIFICATION: Resident-staff communication and response system

**NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 20 (e)

The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

**Rationale and Summary**

None of the enclosed outdoor spaces, such as balconies, patios and courtyards accessible by residents were equipped with a call station that was connected to the staff-resident communication and response system. In some outdoor spaces only, a doorbell style push button was installed, which historically sounded at the nurse's station closest to the outdoor space. Several were tested and they did not sound, and the location of the call was not displayed on any visual device.

Failure to provide the appropriate call stations in the outdoor spaces prevents residents from alerting staff as to their location and the need for assistance and prevents staff from ascertaining the exact time and location that assistance is required.

**Sources**: Observation and test of the system (push buttons), interview with registered staff #103 and acting administrator.
[120]

## WRITTEN NOTIFICATION: Cooling requirements

**NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 23 (2) (a)

The heat-related illness prevention and management plan did not, at a minimum, identify specific risk factors that may lead to heat related illness and required staff to regularly monitor whether residents were exposed to such risk factors and take appropriate actions in response.

**Rationale and Summary**

The licensee did not develop a home-specific heat-related illness prevention and management plan.

Instead, the staff were provided with a corporate template which provided some guidance and examples of what a plan could or should include. Under a subtitle “Procedures” on Page 2 of 6, a statement identified that the home is to “ensure a home specific plan is developed and implemented”.

Missing from the plan template were the specific risk factors that residents could be exposed to throughout the year that may increase their risk of heat related illness. The licensee’s plan was limited to identifying that windows and window covers were to be kept closed. No other risk factors were identified that were specific to the home's environment.

Failure to develop a home-specific heat-related illness prevention and management plan with specific risk factors that expose residents to heat while in their rooms without appropriate interventions identified may increase their risk of heat-related illness.

**Sources:** Review of policy RC-08-01-04 dated June 2023, interview with Director of Care.
[120]

## WRITTEN NOTIFICATION: Air conditioning requirements

**NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 23.1 (2)(b)

The licensee has failed to ensure that air conditioning in the Wildwood home area was operational and in good working order for the purpose of cooling the temperature in resident rooms during the period from May 15 to September 15 in each year, and any time the temperature in an area of the home was measured by the licensee [in accordance with subsections 24 (2) and (3)] reached 26 degrees Celsius (°C) or above, for the remainder of the day and the following day.

**Rationale and Summary**

The make-up air unit with cooling capacity located on the roof top above one of the five resident home areas was not operational at the time of inspection based on air temperature measurements and validation by a certified external contractor. The unit was required to deliver air-conditioned air to resident rooms. The licensee was not aware that the unit was not operational when brought to their attention, nor were they aware how long the unit was not operational. Temperatures of the air supply using an infrared thermometer of 10 resident rooms, all ranged from 24.8 to 25.5 °C, which was the outdoor air temperature at the time of inspection.

An identified resident was assessed as high risk for heat related illness. According to temperature records from a software application which used remote temperature sensors, the resident's room temperature was at or above 26°C on many occasions throughout the year. Their room was located above a space that generated heat. The resident reported that they had complained to various members of the management team in the home numerous times over the last 12 months about the excessive heat in their room. Their complaint was formally documented in early spring 2023. A portable air conditioning unit was installed for the resident approximately 7 days later. During the first date of inspection, when the supplemental portable air conditioner was not on, the room was 26.5°C and the radiant heat panel was on and emitting heat into the room.

**Sources:** Observations, interview with the acting administrator, maintenance lead, registered staff #104, residents, review of progress notes, resident care plans and heat risk assessments.
[120]

## WRITTEN NOTIFICATION: Construction, renovation, etc., of homes

**NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 356 (3) 2.

The licensee has failed to ensure that approval of the Director was received before commencing renovations to the Wildwood and Glen Williams home area shower rooms.

**Rationale and Summary**

A work plan describing how the work was to be carried out, including how residents would be affected and what steps were to be taken to address any adverse effects on residents was not submitted as per s. 356 (4) (a) and (b) of O. Reg. 246/22. Residents who preferred to receive a shower would be affected by such a project, as staff would be required to take them to a shower in another home area and adjust showering schedules for residents in both home areas. The work related to a shower renovation includes noise, dust, debris removal and security concerns.

Observations of the completed Wildwood home area shower area included the removal of the shower cabinet, replacement of the nurse call station covers, replacement of the flooring and wall material and addition of two stainless steel shower barriers (waist height), addition of a privacy curtain track, corner shelf, and sliding shower bar (with handheld shower wand) and controls. The Glen Williams home area shower area had not yet been completed, as the flooring had not been replaced, the shower barriers not installed, and a pipe was left sticking out of the floor (drainage for the former shower cabinet).

Failure to ensure that an approved work plan was developed and implemented posed safety risks for staff and residents.

**Sources:** Interview with the acting administrator, observations, record search of submitted work plans. [120]