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
Feb 20, 2019	2019_598570_0002	001584-19	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Oshawa
82 Park Road North OSHAWA ON L1J 4L1

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

SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 23, 2019.

Critical Incident System Inspection Log #001584-19 - Critical Incident Report (CIR) regarding loss of heat in the home.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Assistant Director of Care (ADOC), Support Services Manager (SSM), Maintenance Worker (MW), Personal Support Workers (PSW), Physiotherapist (PT), residents and family member.

In addition, the Inspector toured the home and observed residents' rooms, observed staff to residents interactions, resident to resident interactions, reviewed temperature logs.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

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

On identified date, the home submitted Critical Incident Report (CIR) to the Ministry of

Health and Long-Term Care (MOHLTC), regarding loss of heat in the home on identified dates. The CIR indicated potential lower temperatures due to failure of heat radiators in residents' rooms.

On identified date, the MOHLTC info line was called to report a flood incident related to the above CIR.

During an interview with Inspector #570, the Director of Care (DOC) indicated that residents rooms in an identified unit were affected and noted with temperatures below 22 degrees Celsius. The DOC provided the Inspector with temperatures logs for identified dates, which revealed recorded temperatures below 22 degrees Celsius in in specified residents' rooms and the hallway in an identified unit. The DOC further indicated that the flooding incident reported to the MOHLTC was related to the heat loss incident in one identified room.

During an interview with the Support Services Manager (SSM), they confirmed to Inspector #570 that they took air temperature on identified date and time with hallway temperature noted at 23 degrees Celsius and residents' rooms at 18+ degrees Celsius.

A review of the temperature record logs, provided to Inspector #570 by the DOC, revealed :

On an identified dates: specified multiple residents' rooms and the hallway on identified unit had recorded temperatures below 22 degrees

On an other identified date and time, in one identified room, temperature was recorded below 22 degrees Celsius.

During an interview with resident #001, the resident indicated that their room was freezing when the heat broke down. Resident #001 further indicated that in an identified common residents' area, there was a draft coming through the window.

During an interview with resident #003, the resident indicated the heat was off on an identified date, and that they had to use space heaters that night. Resident #003's SDM was visiting and indicated to the inspector that on an identified date, the room was chilly.

During an interview with resident #002, the resident indicated that their room was very cold on an identified date.

During an interview with resident #004, the resident indicated that the temperature was very cold on an identified date and that they were given an extra blanket.

During an interview with resident #005, the resident indicated that the room was a little cool and that they like it to be cool.

During an interview with PSW #107, the PSW indicated on an identified unit, it felt colder than normal and that more portable heaters were brought in.

During an interview with PSW #104, the PSW indicated that on an identified date, it was chilly and they had to put on an extra shirt. PSW indicated they were taking air temperature on identified date in residents' rooms and that all rooms were above 22 degrees Celsius expect for one specified room.

During an interview with Support Services Manager (SSM), oversees maintenance at the home, the SSM indicated the loss of heat was reported to them on identified date by the charge nurse. The SSM indicated that an additional staff member was called in to do checks on the residents, monitor space heaters and room temperatures. The SSM indicated taking temperatures on that same date with lowest temperature was at 18 degrees. The SSM acknowledged that residents` room temperatures were not maintained at a minimum of 22 degrees Celsius on specified date.

On an identified date, PSW #104 indicated, they were not instructed to take temperatures in an identified common residents' area. PSW #104 took temperature in the identified common area with Inspector #570. Temperature readings were noted below 22 degrees in four specified parts of the common area.

During the interview, the SSM acknowledged that temperatures in one specified room and identified common area were not maintained at a minimum of 22 degrees Celsius. At the exit meeting with DOC and SSM, the SSM indicated to the Inspector, the temperature in the identified common area was below 22 degrees due to thermostat in the area was found turned off and that measures were put in place to prevent changing of the settings of the thermostat.

During an interview with the DOC, the DOC acknowledged that temperature in the home was not maintained at a minimum of 22 degrees in residents' rooms specifically in one specified room.

The licensee did not ensure that temperature in the home was maintained at a minimum of 22 degrees. [s. 21.]

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 home is maintained at a minimum temperature of 22 degrees Celsius, to be implemented voluntarily.

Issued on this 22nd day of February, 2019

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

Original report signed by the inspector.