Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée


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

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON  L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON  L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111


## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Aug 13, 2021 | 2021_673672_0028 | 012712-21 | Complaint |

## 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

JENNIFER BATTEN (672)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): August 11, 2021**

**The following intakes were completed during the inspection:**

**One intake related to a complaint received regarding the temperatures in the home.**

**During the course of the inspection, the inspector(s) spoke with the Assistant Administrator, Environmental Services Manager (ESM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), housekeepers,
health screeners, maintenance workers, essential caregivers and residents.**

**The inspector(s) reviewed internal policies related to Preventing Heat Related Illnesses and Hot Weather. The Inspector(s) also observed staff to resident and resident to resident care and interactions.**

**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)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 20. Cooling requirements**

**Specifically failed to comply with the following:**

**s. 20. (3) The licensee shall ensure that every designated cooling area in the home is served by air conditioning which is operated, as necessary, to maintain the temperature in the designated cooling area at a comfortable level for residents during the period and at the times described in subsection (1.3). O. Reg. 79/10, s. 20 (3).**

**Findings/Faits saillants :**

The licensee has failed to ensure that every designated cooling area in the home served by air conditioning was operated as necessary to maintain the temperature in the designated cooling area at a comfortable level for residents.

A complaint was received by the Director which indicated the temperature in the home was uncomfortable for the residents, due to extreme heat. The complainant further indicated residents were being negatively affected by heat stress and due to an outbreak occurring on the second floor, residents were being isolated to their rooms and there was no reprieve from the heat.

During an interview, the Environmental Services Manager (ESM) indicated the dining rooms and lounge area were considered to be cooling areas for residents to utilize and residents could attend the cooling area on the second floor for three to five minutes, if they were feeling well and staff donned them in full PPE.

During separate interviews, residents #001, #004 and #008 complained of the temperature in the home and that there was no reprieve from the heat. Each of the residents indicated they were not aware of cooling stations being available and had not been encouraged to utilize the cooling area(s).

Inspector toured the home and noted the home felt uncomfortably hot, humid and stuffy on the second and third floors. At 1730 hours, the temperature outside was noted to be 40.1 degrees with the humidex. The temperature in the second floor lounge was noted to be 28.1 degrees with 68.3% humidity. Charge Nurse #100 notified Inspector that the dining room was also considered to be a cooling area. Upon inspection at 1752 hours, the dining room door was propped wide open and the temperature in the room was noted to be 27.6 degrees with 56.7% humidity. No residents were observed to be in the dining room.

At 1815 hours, 15 residents were observed to be in the lounge area on the third floor. The temperature was noted to be 27.6 degrees with 60.9% humidity. The dining room door was propped wide open and the temperature in the room was noted to be 27.0 degrees with 54.0% humidity. No residents were observed to be in the dining room.

During separate interviews, PSWs #103, #104, #105, #106 and #107 indicated residents on the second floor were not allowed to leave their bedrooms, due to the outbreak on the

resident home area and fans were not allowed to be utilized, as an IPAC measure. PSWs #103, #104 and #105 further indicated that when they arrived on shift, multiple residents were observed to be dressed in inappropriate clothing, such as long sleeved shirts, sweaters and heavy pants which led to the residents observed to be perspiring heavily. Lastly, the PSW staff indicated the dining rooms were not cooling areas for residents to utilize, they had been converted to staff break and storage rooms.

During an interview, the Assistant Administrator (AA) verified the dining rooms had been converted to staff break and storage rooms, but staff could allow a resident to utilize the room for approximately five minutes, if the resident complained they were too hot, were observed to be perspiring heavily and/or requested to utilize the room after staff donned them in the full PPE. The AA indicated they were not aware the temperatures in the lounges and dining rooms were above 26.0 degrees and the cooling system which serviced the home was running constantly at its full ability. The AA further indicated that individual air conditioning units could not be added to resident rooms due to the current electrical system in the home being unable to handle the additional electrical demand, but the electrical panel was being updated in September or October of 2021.

By not ensuring that every designated cooling area in the home served by air conditioning was operated as necessary to maintain the temperature in the designated cooling area at a comfortable level for residents, residents were placed at risk of heat stress and/or heat stroke.

Sources: Complaint received, observations conducted in the home, internal temperature logs, interviews with residents, PSWs, RPNs, RNs, ESM and Assistant Administrator. [s. 20. (3)]

***Additional Required Actions:***

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

**Issued on this 13th day of August, 2021**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## 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

## 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 Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

## Public Copy/Copie du rapport public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l’inspecteur (No) :** | JENNIFER BATTEN (672) |
| **Inspection No. / No de l’inspection :** | 2021_673672_0028 |
| **Log No. / No de registre :** | 012712-21 |
| **Type of Inspection / Genre d’inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Aug 13, 2021 |
| **Licensee / Titulaire de permis :** | Extendicare (Canada) Inc.<br>3000 Steeles Avenue East, Suite 103, Markham, ON, L3R-4T9 |
| **LTC Home / Foyer de SLD :** | Extendicare Oshawa<br>82 Park Road North, Oshawa, ON, L1J-4L1 |
| **Name of Administrator / Nom de l’administratrice ou de l’administrateur :** | Deborah Woods |

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

## 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

## 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 # / No d'ordre :** 001

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 20. (3) The licensee shall ensure that every designated cooling area in the home is served by air conditioning which is operated, as necessary, to maintain the temperature in the designated cooling area at a comfortable level for residents during the period and at the times described in subsection (1.3). O. Reg. 79/10, s. 20 (3).

**Order / Ordre :**

The licensee must be compliant with with s. 20 (3) of O. Reg. 79/10 of the LTCHA.

Specifically, the licensee must:

1. Ensure that designated cooling areas in the home are served by air conditioning which is operated, as necessary, to maintain the temperature in the designated cooling area(s) at a comfortable level for the residents.

2. All cooling areas in the home will have temperatures at a level which is comfortable in the cooling area as affirmed by the residents.

3. Maintain the temperatures at a comfortable level as affirmed by the residents.

4. Staff must be aware of the cooling areas, and offer to assist residents to the cooling areas.

5. There will be a cooling area for every 40 residents in the home.

**Grounds / Motifs :**

1. The licensee has failed to ensure that every designated cooling area in the home served by air conditioning was operated as necessary to maintain the temperature in the designated cooling area at a comfortable level for residents.

A complaint was received by the Director which indicated the temperature in the

home was uncomfortable for the residents, due to extreme heat. The complainant further indicated residents were being negatively affected by heat stress and due to an outbreak occurring on the second floor, residents were being isolated to their rooms and there was no reprieve from the heat.

During an interview, the Environmental Services Manager (ESM) indicated the dining rooms and lounge area were considered to be cooling areas for residents to utilize and residents could attend the cooling area on the second floor for three to five minutes, if they were feeling well and staff donned them in full PPE.

During separate interviews, residents #001, #004 and #008 complained of the temperature in the home and that there was no reprieve from the heat. Each of the residents indicated they were not aware of cooling stations being available and had not been encouraged to utilize the cooling area(s).

Inspector toured the home and noted the home felt uncomfortably hot, humid and stuffy on the second and third floors. At 1730 hours, the temperature outside was noted to be 40.1 degrees with the humidex. The temperature in the second floor lounge was noted to be 28.1 degrees with 68.3% humidity. Charge Nurse #100 notified Inspector that the dining room was also considered to be a cooling area. Upon inspection at 1752 hours, the dining room door was propped wide open and the temperature in the room was noted to be 27.6 degrees with 56.7% humidity. No residents were observed to be in the dining room.

At 1815 hours, 15 residents were observed to be in the lounge area on the third floor. The temperature was noted to be 27.6 degrees with 60.9% humidity. The dining room door was propped wide open and the temperature in the room was noted to be 27.0 degrees with 54.0% humidity. No residents were observed to be in the dining room.

During separate interviews, PSWs #103, #104, #105, #106 and #107 indicated residents on the second floor were not allowed to leave their bedrooms, due to the outbreak on the resident home area and fans were not allowed to be utilized, as an IPAC measure. PSWs #103, #104 and #105 further indicated that when they arrived on shift, multiple residents were observed to be dressed in inappropriate clothing, such as long sleeved shirts, sweaters and heavy pants which led to the residents observed to be perspiring heavily. Lastly, the PSW

staff indicated the dining rooms were not cooling areas for residents to utilize, they had been converted to staff break and storage rooms.

During an interview, the Assistant Administrator (AA) verified the dining rooms had been converted to staff break and storage rooms, but staff could allow a resident to utilize the room for approximately five minutes, if the resident complained they were too hot, were observed to be perspiring heavily and/or requested to utilize the room after staff donned them in the full PPE. The AA indicated they were not aware the temperatures in the lounges and dining rooms were above 26.0 degrees and the cooling system which serviced the home was running constantly at its full ability. The AA further indicated that individual air conditioning units could not be added to resident rooms due to the current electrical system in the home being unable to handle the additional electrical demand, but the electrical panel was being updated in September or October of 2021.

By not ensuring that every designated cooling area in the home served by air conditioning was operated as necessary to maintain the temperature in the designated cooling area at a comfortable level for residents, residents were placed at risk of heat stress and/or heat stroke.

Sources: Complaint received, observations conducted in the home, internal temperature logs, interviews with residents, PSWs, RPNs, RNs, ESM and Assistant Administrator.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents because of the potential for possible heat stress/heat stroke to occur.

Scope: The scope of this non-compliance was widespread, as the temperatures in the cooling areas were observed to be high throughout the home, and the area of non-compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: One or more areas of non-compliance to a different subsection of the legislation were issued to the home within the previous 36

months.
(672)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :** Aug 16, 2021

## 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 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 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416-327-7603

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 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 13th day of August, 2021**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Jennifer Batten

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