Ontario

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

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: September 21, 2023	
Inspection Number: 2023-1134-0004	
Inspection Type: Director Order Follow Up (DOFU)	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Fosterbrooke, Newcastle	
Lead Inspector Sami Jarour (570)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 30, 31, 2023

The following intake(s) were inspected:

- Intake: #00094532 - Director's Order Follow-Up related to O. Reg. 246/22, s. 23.1 (1) with compliance due date (CDD) August 18, 2023.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Director Order #001 related to O. Reg. 246/22, s. 23.1 (1) inspected by Sami Jarour (570)

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

Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: CONDITIONS OF LICENCE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)

The licensee has failed to comply with the conditions of the Director's Order served on August 10, 2023, with a compliance due date of August 18, 2023, related to Inspection #2023-1134-0003.

Specifically, the licensee did not immediately retain a mechanical engineering firm or Heating Ventilation and Air Conditioning (HVAC) Engineer/Technician to determine and install an option to supplement the Home's current system that results in the Home having air conditioning installed, operational and in good working order for the purpose of cooling the temperature in every resident bedroom without over cooling rooms and while maintaining the minimum temperature requirement of 22 degrees Celsius by August 18, 2023.

Rationale and Summary

The licensee failed to provide any documented evidence to the Inspector to indicate an engineer or HAVC technician was retained by the home as required by the Director's Order for the purpose of determining and installing an option that would supplement the home's existing system by the due date of the order on August 18, 2023. Additionally, the licensee failed to maintain air temperatures at a minimum of 22 degrees in multiple residents' rooms, as noted by Inspector #570 and confirmed by the Environmental Services Manager (ESM). An engineering firm completed a preliminary visit to Fosterbrooke LTC home on August 29, 2023, eleven days after the Director's Order Due Date.

Observations conducted on August 31, 2023, between 1105 hrs and 1203 hrs, revealed portable Air Conditioning (AC) units were installed in every resident room in the home. The portable AC units were noted to be vented through existing windows in residents' rooms. During the observations, air temperatures were measured in a central location of residents' rooms about one meter above the floor using a Ministry of Long-Term Care (MLTC) supplied thermometer (TPI 318C digital thermometer). The following was noted:
-Most portable AC units in residents' rooms were set at 24 degrees Celsius, with few rooms noted with AC thermostats set at 22 and 23 degrees Celsius.
-AC units were turned off in seven residents' rooms.
-17 residents' rooms throughout the home had temperatures below 22 degrees Celsius with a

temperature range between 20.3 - 21.9 degrees Celsius.

During observations, a resident indicated they were freezing and always had a blanket because it was cold. A second resident indicated the room temperature right now was heaven to them as the humidity level was down. A third resident indicated the temperature in their room was not too hot or too cold. The resident was in bed, covered in a blanket, at the time of the observation.

Further observations of all residents' rooms and common areas were conducted with the Environmental Service Manager (ESM) on August 31, 2023, between 1207 hrs and 1233 hrs; the ESM used the home's digital thermometer (PROTMEX). The following was noted during the observation with air temperature taken by the ESM and recorded by the Inspector:
-Most portable AC units in residents' rooms were set at 24 degrees Celsius, with few rooms noted with AC thermostats set at 22 and 23 degrees Celsius. In one resident's room, the AC unit was set to dehumidifier mode. The ESM adjusted the settings to 24 degrees Celsius.
-Portable AC units were turned off in five residents' rooms. The AC units were turned on the ESM.
-21 resident rooms and three common areas throughout the home had temperatures below 22 degrees Celsius with a temperature range between 19.5 - 21.9 degrees Celsius.

A review of the home's air temperature logs indicated the air temperature was recorded hourly in five fixed different locations throughout the home. The recorded air temperatures were noted below 22 degrees in one common area that residents use with a temperature range of 20.0 – 21.5 degrees Celsius. The Executive Director (ED) acknowledged that the temperatures in the common area were below 22 degrees Celsius.

A review of an email communication dated July 12, 2023, from an HVAC technician from a contracted company, who, according to the ESM, provided preventative maintenance to the home's HVAC system. The technician noted, "The multiple heat pumps throughout the building that have been installed are very common on older buildings that are no longer keeping up with our changing climate as Temperatures are more severe than 40 years ago". The technician recommended specific repairs. The ED and ESM further indicated that the recommendations were forwarded to the Head office, and no repairs have been completed.

During separate Interviews with the ED and ESM, both indicated that the portable AC units were installed in every resident's room as per direction from the Head Office before August 18, 2023. The ESM further indicated they had no explanation as to why the temperatures recorded during a walk-through with the Inspector were below 22 degrees in multiple residents' rooms and that they would raise the temperature setting in the building on the main thermoset and that they have to do a walk throughout the building three times a day to make sure the temperatures are maintained. The ESM

indicated that an HVAC engineer/technician from an engineering company came to the home on August 29, 2023. No report was provided for that visit eleven days past the due date of the Director's Order.

The engineer from Revera confirmed in an email to the Inspector that they visited Fosterbrooke LTC home on July 13, 2023, and reviewed the mechanical drawings on record and the 2021 Building Condition Assessment report. They explained that the only option was installing portable air conditioning units, which did not require engineering input or design. They further explained that an engineering company completed a preliminary visit to Fosterbrooke LTC home on August 29, 2023, and require at least four weeks to do a detailed heat loss calculation and other design checks to ensure the existing cooling equipment is working as designed.

Failure to comply with the conditions of the Director's Order to determine and install a cooling option that supplements the home's existing system has resulted in overcooling of multiple residents' rooms below 22 degrees Celsius, putting residents at risk of discomfort.

Sources: observations of residents' rooms; record reviews of email communications; Air temperature records dated August 18-29, 2023; Email communication records related to HVAC from HVAC technician and an engineer from Revera; interviews with residents, Environmental Services Manager and the Executive Director. [570]

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

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Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.