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
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: July 14, 2023	
Inspection Number: 2023-1401-0003	
Inspection Type: Complaint	
Licensee: Steeves & Rozema Enterprises Limited	
Long Term Care Home and City: Lanark Heights Long Term Care Centre, Kitchener	
Lead Inspector Bernadette Susnik (120)	**Inspector Digital Signature** Bernadette Susnik Digitally signed by Bernadette Susnik Date: 2023.07.25 13:38:43 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 13, 20, 2023 and July 6, 2023
The inspection occurred offsite on the following date(s): June 29, 2023

The following intake(s) were inspected:

- Intake: #00088071 - Complaint regarding air conditioning in the home.
- Intake: #00088271 - Compliant regarding locked windows, and air conditioning in the home.
- Intake: #00088280 - Complaint regarding cooling requirements and locked windows in the home.

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

Resident Care and Support Services
Safe and Secure Home
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Cooling requirements

NC #001 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

Missing from the heat related illness prevention and management plan were the specific environmental risk factors that residents could be exposed to throughout the year that may increase their susceptibility to heat-related illness. These risk factors include but are not limited to the location of resident rooms in the building (top floor vs lower floor), orientation to direct sun exposure (causing windows, walls, floors, and ceilings to absorb heat and radiate it into the rooms), use of heat generating equipment in resident rooms (oxygen concentrators, electronics), limitations of air conditioning or ventilation systems in the home and heat from individual room heaters. The plan included response and preventative measures such as use of fans, cooling supplies (cooling jackets, ice packs, fans and cool foods and fluids), closing windows and drapes, reducing activities, cool sponging, loose clothing, and careful consideration in using air conditioning units when residents have respiratory illness. The plan did not identify how staff could access portable air conditioning units, when and how they would be distributed, and when they should be installed or uninstalled.

During the inspection, despite the fact that the mechanically cooled supply air being vented into resident rooms was cooler than outdoor air temperatures and confirmed to be from an operational air conditioner, 4 identified resident rooms in the A wing were over 25°C. Several residents expressed discomfort with the temperature in their rooms. Three complaints were received regarding excessive heat in resident rooms and the substitute decision makers were concerned about the residents' health. These rooms had their windows closed, exposed to the sun for most of the day, had window covers that did not block out the heat, had fans (which

were ineffective at reducing air temperatures), and some had heat generating equipment in their rooms that emitted continuous heat when on.

Failure to ensure that the heat-related illness prevention and management plan includes all relevant risk factors that may lead to heat-related illness which also includes the appropriate actions to take in response may place residents at higher risk of heat-related illness.

Sources: Observations, interviews with staff, residents, families, review of the Heat Related Illness Prevention and Management Plan, rev April 11, 2022.
[120]

WRITTEN NOTIFICATION: Cooling requirements

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 23 (2) (d)

The heat related illness prevention and management plan, did not at a minimum, include a protocol for appropriately communicating the heat related illness prevention and management plan to residents, staff, volunteers, substitute decision-makers, visitors, the Residents' Council of the home, the Family Council of the home, if any, and others where appropriate.

Rationale and Summary

The plan included how the heat warnings would be conveyed to staff and residents, but no information was included about how the plan would be shared with the appropriate groups or individuals.

Sources: Review of the Heat Related Illness Prevention and Management Plan, rev. April 11, 2022, interview with administrator, manager of resident care and maintenance lead.
[120]

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 11.

The licensee has failed to ensure that a plan of care for three identified residents was based on, at a minimum, interdisciplinary assessment of seasonal risk relating to heat related illness, including protective measures required to prevent or mitigate heat related illness.

Rationale and Summary

The care plans for all three residents, which were assessed as either high, moderate, or low risk for heat related illness included response measures that were identical. All included what heat-related illness signs and symptoms to monitor and the interventions that would apply. These interventions included the use of a fan, tepid sponging, promotion of loose light weight clothing, and to keep windows and window covers closed. Although these responses may alleviate some heat related symptoms, they are not considered protective measures against heat exposure or capable in all cases in preventing heat related illness. The care plans when developed by registered staff, did not consider the location of the resident's room in the building (top floor vs lower floor), orientation to the sun, use of heat generating equipment in resident rooms (oxygen concentrators, electronics), limitations of air conditioning or ventilation systems in the home and heat from individual room heaters. Use of specific cooling equipment or supplies as necessary to protect residents from heat-related illness is now required under s. 23(2)(d) of Ontario Regulation 246/22.

During the inspection, all three residents had room temperatures that were at or above 26°C, despite the fact that their rooms were served by a mechanical air conditioning system. Two of the residents had heat generating equipment in their rooms, contributing to additional heat. Although blinds and windows were closed, and fans in use, the heat persisted. These rooms were exposed to the sun for a portion of the day and the blinds were not designed to block the heat. Three complaints were received by either a resident or their substitute decision makers that the rooms were overly hot, making everyone in the room uncomfortable.

Failure to assess the resident's environment when developing a plan of care and to

subsequently include the protective measures in the plan of care for staff awareness and implementation may increase the resident's risk to heat-related illness.

Sources: Observations, interviews with staff, residents and families, review of resident care plans and heat risk assessments.
[120]