Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 4, 2014	2014_189120_0004	H-000043/H-000048-14	Complaint

Licensee/Titulaire de permis

MARYBAN HOLDINGS LTD
3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6

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

OAKWOOD PARK LODGE
6747 OAKWOOD DRIVE, NIAGARA FALLS, ON, L2E-6S5

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

BERNADETTE SUSNIK (120)

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): January 22, 2104

During the course of the inspection, the inspector(s) spoke with the administrator, environmental services supervisor, maintenance person, residents, registered and unregistered staff regarding linen supply and air temperatures in the home.

During the course of the inspection, the inspector(s) toured the building, checked random resident rooms and washrooms, took air temperature readings, observed the condition of the hot water heaters in resident washrooms reviewed air temperature logs and observed the quantity of linens in the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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	Legendé 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 :

The home was not maintained at a minimum temperature of 22 degrees Celsius.

On January 22, 2014, a tour of the home was conducted to determine if the air temperature was being maintained at a minimum of 22C. 3 identified resident rooms were monitored for ambient air temperatures using a digital thermometer which was positioned in the center of each of the rooms for a minimum of 15 minutes. The temperatures were 19.9C, 21C and 20C. The home's heating is provided by hot water which circulates through pipes that run through resident bathrooms, bedrooms and

common areas.

When other resident rooms were toured, wall mounted thermostats were checked in rooms where the air temperature felt cool. Many thermostats were noted to be showing an ambient air temperature of between 19 and 22C and were set to over 30C. The accuracy of all the thermostats could not be established, but several were within 1-2C of the digital thermometer being used by the inspector. The Environmental Services Supervisor (ESS) explained that the thermostats were not adjustable, that the hot water circulating through the pipes was the same temperature regardless of the setting on the thermostat.

A laser thermometer was also used to take surface temperatures of heaters in resident bedrooms and washrooms to determine if any variations existed. The heater in one identified room was 36-37C and the heater in another room was 43-46C. The variance in temperatures was explained by the ESS as possibly being related to sediment or air in the pipes in the vicinity of the heater and that purging of the pipes may improve the heating capacity. A whole home purging of the system was conducted prior to the heating season in September 2013. However, the hot water boilers were drained and cleaned in November 2013 but the lines were not re-purged, possibly creating the air pockets in the lines. A number of resident washrooms were noted to be cooler than bedroom air temperatures, one in particular did not have any heat. The heater was not warm to the touch. Some washrooms were provided with heaters and others were not.

It was also noted that the metal fins surrounding the heated pipe in many resident washrooms were damaged, dirty and caked in dust and debris. The fins act to radiate the heat from the pipe out into the surrounding area. When damaged and dirty, the heat output is reduced.

Air temperatures were not being monitored within the home after September 2013, once the risk of extreme heat had subsided for the season. With the exception of one thermometer at the main nurse's station, ambient air thermometers were not available in corridors or common areas to confirm that air temperatures were being maintained at 22 degrees Celsius. A maintenance log was reviewed which was available to staff members to record temperature concerns for the maintenance person. Staff documented cold temperature concerns on November 25, 2013 for one identified resident room in the 300 wing, November 14, 2013 for the main lounge, November 24, 2013 for a window not closing completely in a room in the 200 wing and staff asking

for sealant to be put on the same window on December 12, 2013. A statement of "very cold" was written in the log on January 2, 2014 and "no heat" on January 3, 2014. The maintenance person did not record any follow-up action except the word "ok" or "heat working". On January 7, 2014, following several days of -30 degree temperatures, a concern was raised by a visitor who prompted the management of the home to initiate air temperature monitoring. However the monitoring was conducted using a laser thermometer which is only capable of recording surface temperatures. According to the maintenance person, the temperature of the floor in resident rooms was taken. In reviewing the temperature logs, the temperatures ranged from 18C to 24C from January 7 to 22, 2014. The temperatures were not accurate ambient air temperatures. A contractor was contacted and arrived on January 8, 2014 and identified that the home's hot water boiler system's temperature controller was improperly programmed and indoor air temperatures dropped.

In an effort to increase air temperatures, the management of the home shut down the main fresh air supply system (which is not fully heated) and applied silicone caulking to the resident's windows. However, other causes regarding the efficiency of the heating system were not fully investigated as identified during the inspection. [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.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

A sufficient supply of clean face cloths was not available in the home for use by residents.

On January 22, 2014, at 1:30 p.m., before the afternoon linen delivery, 6 linen closets, random resident rooms/washrooms and the laundry room were checked for face cloths that would sufficiently meet the needs of each of the 153 residents in the home. Less than 50 face cloths could be identified between the linen closets and the laundry room. Resident rooms and washrooms were randomly checked and very few face cloths observed. Bath towels were in sufficient supply and these were noted in most closets. Residents and staff who were interviewed both identified that shortages of face cloths have occurred on a regular basis. After 2 p.m., as staff were delivering clean linen to resident rooms and linen closets, no additional face cloths were observed on the carts or in any of the linen closets. Staff identified that the number of face cloths that were being delivered would not suffice to supply each resident with one face cloth each.

The administrator confirmed that 10 dozen face cloths were available in the building, but were not in circulation at the time of inspection. [s. 89(1)(b)]

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 a sufficient supply of clean face cloths is available in the home for use by residents, to be implemented voluntarily.

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Issued on this 4th day of February, 2014

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