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 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

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 9, 2018	2018_539120_0041	024661-18	Complaint

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

The Village of Winston Park
695 Block Line Road KITCHENER ON N2E 3K1

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): September 24, 2018

Log #024661-18 related to excessive heat in the home.

During the course of the inspection, the inspector(s) spoke with the Environmental Services Supervisor, Director of Care, Registered staff, housekeeping staff and residents.

During the course of the inspection, the inspector toured the home, measured air temperature and humidity levels in a resident room and several common spaces, reviewed the licensee's policies and procedures for hot weather related concerns, heat stress assessments and residents' plan of care.

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

During the course of this inspection, Non-Compliances were issued.
- **2 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	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. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written hot weather related illness prevention and management plan met the needs of the residents and was developed in accordance with prevailing practices and implemented when required to address the adverse effects on residents related to heat.

Prevailing practices are generally accepted widespread practices which are used to make decisions. The Ministry of Health and Long Term Care developed a guidance document entitled "Guidelines for the Prevention and Management of Hot Weather Related Illness in Long Term Care Homes, 2012", which was shared with all Long Term Care Homes in 2012. The guidance document includes information with respect to monitoring the internal building environment when outdoor conditions exceed a temperature of 25 degrees Celsius (C) and interventions to reduce heat related illness and to reduce heat in the building when the Humidex reaches 30 [some discomfort begins at this level].

The Humidex is an index number that is used to describe how the weather feels to the average person and is determined when the effect of heat and humidity are combined. This is to ensure that cooling systems or other cooling alternatives in the building are functional and able to provide relief to residents in certain designated areas should they require it. The guidance document also includes information with respect to enhanced resident symptom monitoring related to excessive heat. Heat warnings were issued for the Province of Ontario, including the Region of Kitchener/Waterloo, beginning on June 17, 2018, when the Humidex approached or exceeded 40. Values over a Humidex of 35 were experienced on June 17, 18, 29, 30, July 1-5, 15, 16, August 5, 6, 27-29, September 1-5, 2018, at which time designated cooling areas, which can include dining rooms and common spaces, must be available to residents if a home's central air conditioning system is not adequate, functional or has not been provided.

Four complaints were received between August 16 and September 5, 2018, that the long term care home was uncomfortably warm beginning early August 2018. The complainants reported that the common areas, such as dining rooms and sitting areas, resident rooms and corridors were all equally hot and that they had no particular area to go to get relief other than the retirement home located next door. One complainant identified that their family member had no appetite during the heat waves and that another resident was heard complaining about not being able to breathe with the excessive heat. The RAI-MDS Co-ordinator stated that residents and families did

complain about being very uncomfortable, but no residents were treated for dehydration, heat exhaustion or heat stroke.

According to the Environmental Services Supervisor (ESS), the home's air conditioner for the common areas (dining rooms and lounges) on both the first and second floors failed on August 6, 2018. The unit was replaced and installed on September 24, 2018. The home's corridors were however cooled by a different system identified as a heat recovery ventilator (HRV). One HRV was located at both ends of each corridor in the three different home areas. The units were functional throughout the summer, but were limited as to how much air volume could be cooled during times of extreme heat and humidity conditions outside.

According to the ESS on September 24, 2018, air temperature and humidity readings were not recorded for designated cooling areas in the home between June 2018 and the date of inspection. No records could be provided to indicate whether the cooling areas were sufficiently cooler than the rest of the home or outdoors between June 17, 2018 and September 5, 2018. However, air temperatures were recorded by housekeeping staff beginning on August 1, 2018, and according to housekeeper #106, air temperatures were taken mostly in the two corridors on the second floor. A digital thermometer was used by placing it on the housekeeping cart and recording the readings when the carts were parked in the corridor outside of resident rooms on the second floor or in the front lounge or television room. The first floor temperatures for the Eby home area were not included in the records provided. The ESS provided an "Air Temperature Recording Sheet" for the month of August and September 2018. Temperatures were missing for August 3-5, 9, 13, 21, 22, 28 and September 2-6, 15, 16, 2018. No records were kept prior to August 2018. No humidity levels were monitored or recorded and therefore a Humidex could not be calculated. Air temperature records taken by housekeepers revealed temperatures between 23.3 and 26C in corridors.

During the inspection, a tour of the two dining rooms, and lounge areas within the home were conducted. No hygrometers [device that measures both temperature and humidity] were seen in any common space on the second floor and a temperature gauge was noted in the Eby dining room. Two new hygrometers were purchased within the last week by the ESS and placed on each of two nurse's desks (near warm light fixtures). As the outdoor air temperature had dropped to 17.5C, the adequacy of the designated cooling spaces could not be verified at the time of inspection.

The ESS was asked to provide any policies, procedures or plans related to managing hot

weather related illness. Two policies were provided, but neither related to environmental or building services. Both policies were related to nursing services. One was entitled "Extreme Hot and Cold Weather Conditions/Temperatures" (tab 04-32) and the second was entitled "Heat Exhaustion" (tab 04-40). The latter policy included a statement that "villages that do not have central air conditioning will have a designated cooling area available". Neither policy included information related to monitoring air and humidity levels, by whom, when or how often, a trigger Humidex level to begin implementing the necessary interventions required to keep residents comfortable and safe or where the designated cooling areas were located or would be located if the central air conditioning unit failed for any length of time.

The licensee's hot weather related illness prevention and management plan was not developed in accordance with prevailing practices and implemented when required to address the adverse effects on residents related to heat. The plan provided by the licensee was not developed in accordance with the "Guidelines for the Prevention and Management of Hot Weather Related Illness in Long Term Care Homes, 2012", related to the monitoring of the designated cooling areas with respect to the Humidex and what steps or actions needed to be taken if the existing cooling systems could not provide adequate cooling in the required designated spaces. [s. 20. (1)]

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 written hot weather related illness prevention and management plan meets the needs of the residents and is developed in accordance with prevailing practices and implemented when required to address the adverse effects on residents related to heat, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including a breakdown of major equipment or a system in the home.

The General Manager reported to the Resident's Council on September 23, 2018, that the air conditioner for the dining rooms and common spaces in the Long Term Care home had malfunctioned on August 6, 2018. The air conditioner was replaced on September 24, 2018. The air conditioner was considered a major system in the home, as it provided air conditioning to the common spaces during extreme heat weather conditions.

A critical incident form was not completed electronically and submitted to the Ministry of Health and Long Term Care via the Critical Incident Reporting System. [s. 107. (3) 2.]

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Issued on this 26th day of October, 2018

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

Original report signed by the inspector.