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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 10, 2018	2018_539120_0035	017848-18	Complaint

Licensee/Titulaire de permis

St. Joseph's Health System
50 Charlton Avenue East Room M146 HAMILTON ON L8N 4A6

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

St. Joseph's Lifecare Centre
99 Wayne Gretzky Parkway BRANTFORD ON N3S 6T6

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): July 19, 2018

A complaint was received related to excessive heat in the home and resident heat stress management interventions.

During the course of the inspection, the inspector(s) spoke with the Chief Financial Officer, Director of Care, Assistant Director of Care, maintenance staff, residents, registered staff, personal support workers and housekeepers.

During the course of the inspection, the inspector toured three home areas, took air temperature and humidity readings, reviewed maintenance service reports, hot weather management plans and maintenance report logs.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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 that met the needs of residents was developed in accordance with prevailing practices and was 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 Celcius (C) and interventions to reduce heat. 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 monitoring for nutrition and hydration, body temperature, heat cramps, heat rash, headache, excessive sweating, weakness, dizziness and other heat-related symptoms.

The licensee's "Hot Weather Plan" (1-HR-31) dated January 7, 2015, was reviewed to determine compliance with this section. It included a procedure to "monitor indoor temperature and humidity levels during peak times" and to "initiate a response if the Humidex was 29 or higher". The Humidex is an index number that is used to describe how the weather feels to the average person and is reached when the effect of heat and humidity are combined. The term "peak times" was not defined or clarified, the person(s) responsible for monitoring temperatures and humidity levels was not identified, how temperature and humidity levels were to be monitored, how often and where (and with what equipment) was not specified. The plan also included a statement that "cooling equipment can be provided such as fans" and that "staff shall be encouraged to take frequent short breaks if needed". No additional details were included.

According to a complainant, air conditioning was not functioning adequately in the main corridor (which serviced the majority of resident rooms) on each of three floors occupied by residents on the south side of the building from July 4 to July 17, 2018. The complainant stated that it was hot and uncomfortable, especially at night when residents had to be in their rooms. No specific heat-related health effects were reported by the complainant and they confirmed that designated cooling areas (dining rooms and

lounges) were comfortable and cooler than the rest of the home areas. The complainant expressed concerns that the management staff were not very responsive when the uncomfortable conditions were brought to their attention on July 4 and 5, 2018. No portable fans were available to provide to residents and for the corridors, very few were available and had to be borrowed from other non-resident areas of the home. In addition, there was no plan to allow staff to take more frequent short breaks and to ensure that at the same time, staffing levels were adequate to provide enhanced monitoring of resident symptoms and to encourage residents to drink more fluids.

During a visit to the home on July 19, 2018, in response to the concerns, records could not be provided identifying what the air temperature and humidity readings were for the past several months in any part of the home. One of three maintenance employees (#001), identified that their computer software program, which was connected to their heating and cooling systems, could not store air temperature data beyond three days and that humidity data was not stored at all. The employee did not separately document what the readings were between June 29 and July 5 and on July 15 and 16, 2018, during a provincial heat warning. A visit to several different home areas on the south side of the building was made and registered staff and personal support workers were not able to produce any temperature and humidity logs or state what the temperature was between June 29 and July 16, 2018, in any part of the home. Interviews with housekeeping staff, personal support workers and several residents identified that it was hot and uncomfortable prior to the inspection. Observations were made that very few fans were available and maintenance staff #001 confirmed that very few fans were kept in storage and that they had purchased three large fans on July 6, 2018.

On July 4 and 8, 2018, the home's internal maintenance log included notations from staff that the air conditioning was not working on the south loop. Service records provided by the heating and cooling contractor dated July 4, 2018, and July 17, 2018, confirmed that work was completed on cooling unit compressors on the south side of the building. A visit by the contractor to the home on July 4, 2018, included the cleaning of cooling unit compressors, creating more cooling. A visit to the home on July 9, 2018, included a failed cooling unit compressor [responsible for the main corridor and resident rooms on each of three floors] and damaged wiring which was replaced on July 17, 2018. Between July 9 and 17, 2018, the compressor was only partially able to provide cooling, but the extent or degree of cooling was limited during extreme heat conditions which were prevalent from June 29 to July 5, July 15 and 16, 2018.

The licensee's hot weather plan was not developed or implemented to address the

specific issues identified above. The plan lacked guidance for staff in monitoring the internal building environment, how enhanced monitoring for resident hydration and other risks would be undertaken if levels of staffing were to be reduced due to more frequent breaks and/or reduced staffing due to illness and what strategies or alternatives would be available to staff should cooling systems fail. [s. 20. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 92. Designated lead — housekeeping, laundry, maintenance

Specifically failed to comply with the following:

s. 92. (1) The licensee shall ensure that there is a designated lead for each of the housekeeping, laundry services and maintenance services programs, but the same person may be the designated lead for more than one program. O. Reg. 79/10, s. 92 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a designated lead for the maintenance services program, but the same person may be the designated lead for more than one program [housekeeping, laundry, maintenance]..

During an inspection of the home on July 19, 2018, related to maintenance services, a designated lead for the maintenance program was not established. When maintenance person #001 was asked who he and the other two maintenance persons reported to, he said the Director of Care (DOC), but otherwise, the three managed the department on their own. The DOC confirmed on July 26, 2018, that the maintenance staff reported to them and that they had managed maintenance related administrative tasks for several months. Some of the tasks included organizing and communicating with contractors who were required to perform work in the home and submitting plans and proposals to the Ministry of Health and Long Term Care. The DOC confirmed that a different person was the designated lead for the housekeeping and laundry services. According to s. 213(1)5. of O. Reg 79/10, the DOC is required to work 35 hours per week in the role or position of the DOC. When the DOC was asked if they kept track of their hours in both roles, the reply was no. In order to comply with both this section and s.213(1)5., the licensee would be required to ensure that the DOC completes 35 hours per week in the role of DOC and that the hours spent performing tasks as a maintenance lead would need to be separate and adequate to meet the needs of the maintenance department. In addition, the maintenance lead would be required to have knowledge of prevailing practices related to maintenance, which the DOC did not have.

The licensee therefore did not ensure that there was a designated lead for the maintenance services program. [s. 92. (1)]

Issued on this 10th day of August, 2018

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

Original report signed by the inspector.