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 18, 2024
Inspection Number: 2024-1463-0003
Inspection Type: Complaint
Licensee: Mill Creek Care Centre
Long Term Care Home and City: Mill Creek Care Centre, Barrie

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 3, 4, 2024
The inspection occurred offsite on the following date(s): July 5, 2024

The following intake(s) were inspected:

- Anonymous complaint related to lack of air conditioning and excessive temperatures in the home.

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

Resident Care and Support Services
Safe and Secure Home

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)

Cooling requirements

s. 23 (2) The heat related illness prevention and management plan must, at a minimum,

(a) identify specific risk factors that may lead to heat related illness and require staff to regularly monitor whether residents are exposed to such risk factors and take appropriate actions in response;

The licensee has failed to ensure that the heat related illness prevention and management plan (HRIPMP), at a minimum, included how to regularly monitor whether residents were exposed to risk factors associated with heat-related illness (HRI) and take appropriate actions in response.

Rationale and Summary

The HRIPMP did not include any direction for staff as to what actions to take when resident room air temperatures reached or exceeded 26˚C or where residents complained of being uncomfortable. The HRIPMP did not include which rooms were being remotely monitored by an automation system called Blue Rover. Direction for staff was limited to following up on alerts in a timely manner. Which staff received the alerts, and how they received them was not included. A total of three resident rooms were monitored by the temperature sensors and reached 26˚C or higher on several occasions in June and July 2024. No documentation was made by nursing staff as to what interventions or actions were taken to mitigate resident exposure to HRI risks in these rooms. The HRIPMP did not include what appropriate actions to

take or what documentation was to be completed in these situations.

Failure to provide clear direction for staff in the HRIPMP may lead to inconsistent practices and lack of appropriate and timely response for residents who may be at risk for HRI.

Sources: Review of the HRIPMP, temperature logs and resident care plans, interview with the Environmental Services Supervisor, maintenance staff and nursing managers.

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)
Cooling requirements
s. 23 (2) The heat related illness prevention and management plan must, at a minimum,
(d) include the use of air conditioning, cooling equipment and other resources, as necessary, to protect residents from heat related illness; and

The licensee failed to ensure that the heat related illness prevention and management plan (HRIPMP), at a minimum, included the use of air conditioning, cooling equipment and other resources, as necessary, to protect residents from heat related illness (HRI).

Rationale and Summary

The HRIPMP did not include any home-specific information about how the resident rooms were cooled, where designated cooling areas were located, and whether any

portable air conditioners or fans were available for staff to implement. The dining rooms and activity spaces were air conditioned, but not identified in the HRIPMP. During the inspection, three portable air conditioning units were available, and two were in use. Fans were observed in use in corridors and resident rooms, but those in resident rooms were provided by families and residents, and not the licensee. Staff identified that they did not have any fans in storage for immediate installation when necessary and stated that they often had to take from one area to serve another.

Nursing managers reported that they did not have any cooling supplies in the home such as cooling vests.

Several residents complained that their rooms were hot and uncomfortable and would have appreciated the installation of portable air conditioners, as they felt the system in the building for resident rooms was not providing adequate cooling relief during extreme heat episodes.

Failure to include options and criteria in the HRIPMP about the use of air conditioners, cooling equipment and other resources, and having them available for staff to implement limits appropriate interventions and response times in mitigating possible HRI.

Sources: Review of the HRIPMP and interview with residents and nursing managers.

WRITTEN NOTIFICATION: Cooling requirements

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 23 (2) (e)
Cooling requirements
s. 23 (2) The heat related illness prevention and management plan must, at a

minimum,
(e) 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.

The licensee has failed to ensure that the heat related illness prevention and management plan (HRIPMP), at a minimum, included a protocol for appropriately communicating the HRIPMP to resident, staff, volunteers, 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 HRIPMP included a statement that the plan must be communicated to families, staff and residents. No specific protocol as to how this would be accomplished was included. Reference to informing the Family and Resident Councils was not included.

Failure to include a clear protocol for staff to follow with respect to communicating the HRIPMP to those identified above, may increase their risk to HRIs when they are not made aware of heat advisories and potential interventions.

Sources: Review of the HRIPMP, interview with nursing managers.

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 11.
Plan of care

s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
11. Seasonal risk relating to heat related illness, including protective measures required to prevent or mitigate heat related illness.

The licensee has failed to ensure that the plan of care for three different residents included protective measures required to prevent or mitigate heat related illness (HRI). Protective measures include but are not limited to the use of cooling equipment, supplies and other resources.

Rationale and Summary

The plans of care for three residents, which were assessed as either high, moderate, or low risk for HRI, included identical interventions, despite each resident having different risk factors related to their clinical profile and exposure to different environmental conditions in their rooms. Although none of the three residents had an oxygen concentrator in their rooms, other residents did, and they contributed heat to the room. Some residents were located in areas of the building which were subjected to more direct sun or warmer conditions on upper floors. The plans of care were not individualized to ensure that the interventions were appropriate and applicable to each resident. Environmental risk factors and interventions were not incorporated into the decision making when the plan of care was developed for the three residents.

The interventions in the plans of care for all three residents included mitigating strategies such as “monitor or observe for heat-related symptoms; suitable light weight clothing; encourage or push fluids, and close window and drapes.” These strategies may or may not prevent HRI and are not considered protective measures that air conditioning equipment can provide.

Failure to assess the resident's environment as part of a comprehensive care plan in addition to clinical risk factors 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 of resident rooms, review of heat risk assessments, plans of care, and interviews with nurse managers, and residents.

COMPLIANCE ORDER CO #001 Air conditioning requirements

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 23.1 (3)
Air conditioning requirements
s. 23.1 (3) The licensee shall ensure air conditioning is operating, and is used in accordance with the manufacturer's instructions, in each area of the long-term care home described in subsection (1) in either of the following circumstances:
1. When needed to maintain the temperature at a comfortable level for residents during the period and on the days described in subsections (1) and (2).
2. When the use of air conditioning has been identified in order to protect residents from heat related illness in the heat related illness prevention and management plan.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall comply with O. Reg. 246/22, s. 23.1 (3)

The licensee must:

1. Develop and implement a process to identify which resident rooms are more likely to be impacted by elevated outdoor temperatures (when 26˚C or

higher). Once identified, document the room locations and include what actions or strategies (which includes supplemental air conditioning units) were implemented by staff to ensure that resident room temperatures were adjusted to a comfortable level for residents. The process shall also include the frequency to monitor the temperature of the affected resident rooms.

2. Make portable air conditioning units readily available to staff to promote timely installation where and when necessary, and with the permission of residents and/or their substitute decision maker. Where permission has not been granted, the licensee shall ensure that alternative strategies are promoted as per the resident's plan of care. The date and reason for installing or uninstalling the units shall be documented in the resident's progress notes.

3. Where a portable air conditioning unit is required to be installed in a particular resident room, the reason shall be stated in the resident's plan of care, along with any operational instructions for staff to follow, if there are any.

Grounds

The licensee has failed to ensure that air conditioning was operating in every resident bedroom in the following circumstances:

1. When needed to maintain the temperature at a comfortable level for residents on any day on which the outside temperature forecasted by Environment and Climate Change Canada for the area in which the home was located was 26 degrees Celsius or above at any point during the day; and any time the temperature in an area in the home was measured by the licensee in accordance with subsections 24 (2) and (3) reached 26 degrees Celsius or above, for the remainder of the day and the following day.

Rationale and Summary

On some days in June and July 2024, when outdoor temperatures exceeded 26˚C, indoor temperatures also exceeded 26˚C. During these occurrences, some residents were not comfortable, and their rooms were not supplemented with cooling equipment to reduce the level of heat and humidity to a comfortable level.

A complaint was received that included an assumption that the resident rooms were not air conditioned. The complainant identified that the ventilation and air conditioning system could not reduce the air temperatures and humidity in the home to comfortable levels when heat advisories were issued.

Three residents during the inspection complained that they were hot and uncomfortable in their rooms on a specified day in July 2024, and on other days in June and July 2024. Two residents stated they had to install their own fans, because they felt unwell when it was hot. All three reported that no one in the home did anything about their discomfort, meaning that no air conditioning equipment was installed to supplement any existing ventilation or cooling that served the resident rooms. Registered staff and environmental services staff were aware of resident complaints, and it was common knowledge that certain rooms and sections of the building were warmer than others.

During the inspection, outdoor conditions were 28.2˚C with a relative humidity of 97% at 1 p.m. These two values were calculated using a Humidex chart and were noted to be at 43. A Humidex of 30 or higher is considered to cause some discomfort. Above 45 is considered dangerous. Indoor conditions were measured by the inspectors between noon and 1 p.m. in resident rooms. Windows were already closed, and drapes drawn when rooms were entered for all but one room. The following measurements were made;

Room on second floor – 26˚C

Room on third floor – 27.2˚C, 76.7% (Humidex 36) (window was closed by inspector and temperature taken ten minutes after)

Room on third floor – 26˚C, 72.3% (Humidex 33)

Room on third floor – 27.8˚C, 72.3% (Humidex 34)

The licensee's measurements for the second-floor room included a temperature of 26 to 26.6˚C over the course of three shifts. Temperature records for three days in June 2024, included an average Humidex value of 30 for rooms on the first and second floors. The licensee did not have any temperature measurements for review with the exception of the three specific rooms noted to be measured above and the common areas.

The licensee's heating, air conditioning and ventilation contractor confirmed that the resident rooms were served by two make-up air tempering systems located on the roof. The systems were designed to bring in 100% fresh air, and to dehumidify and cool the air, and described the units as being limited in reducing the heat and humidity when outdoor conditions were above 26˚C and 60% relative humidity. Other factors such as level of insulation, direct sun light exposure and open windows also contribute to the ability for a system to cool an indoor environment.

Nursing managers identified that residents did not receive any supplemental air conditioning equipment in their rooms, and they did not have access to enough equipment to offer all residents who complained of being hot or warranted cooling based on their heat risk factors.

Failure to monitor resident rooms at risk of exceeding 26˚C or of becoming uncomfortable for residents when outdoor air temperatures reach or exceed 26˚C may impact their wellbeing and contribute to heat related illness.

Sources: Observations of the air make-up units, took air and humidity measurements, interview with a heating/ventilation and cooling technician,

residents, nursing managers, Environmental Services Manager, maintenance staff, review of air temperature logs, and an engineer's air conditioning assessment letter.

This order must be complied with by August 12, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator

Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of

appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.