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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 8, 2016	2016_377502_0011	021196-16, 021324-16	Complaint

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

Midland Gardens Care Community
130 MIDLAND AVENUE SCARBOROUGH ON M1N 4B2

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

JULIENNE NGONLOGA (502)

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 21, 22 and 25, 2016.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DON), Assistant Director of Care (ADOC), Director of Environmental Services, Director of Resident Services, Registered Nurse (RN), Registered Practical Nurse (RN), Personal Support Worker (PSW), Physiotherapist Assistant (PTA), family members, and residents.

During the course of the inspection, the inspector toured all floors, took air temperature and humidity readings in designated cooling areas, corridors and randomly selected resident rooms, reviewed air temperature logs, resident heat stress assessments and other clinical records, reviewed resident and family council meeting minutes, heating and cooling maintenance records, and licensee's related policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **5 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident and the goals the care is intended to achieve.

On specified dates, Ministry of Health and Long-Term care ActionLine received two complaints. The complainants voiced a concern that air conditioning was not available in the home and the air temperature was very hot.

Review of the Heat Risk Assessment History Report on specified period, revealed resident #011 and resident #012 were identified as being at high heat risk. The written plans of care for resident #011 and #012 did not include interventions for the high heat risk that was identified.

Interview with DON #114 confirmed resident #011 and resident #012's written plan had not included the goal and interventions related to Heat Risk level identified during the annual assessment. However, interview with RNs #103, #106, #111, RPNs #105 and #109 revealed they were aware of intervention required for the resident identified as being at heat high risk level. [s. 6. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan and policy put in place was complied with.

On specified dates, Ministry of Health and Long-Term care ActionLine received two complaints. The complainants voiced a concern that air conditioning was not available in the home and the air temperature was very hot.

Review of home's policy titled Hot Weather - Management of Risk #VII-G-10.10 revised on November 2015, and Heat Contingency Protocols #VII-G-10.10 (a) dated July 2015, stated that in the event of heat alert or heat wave, staff are required to close all curtained areas and windows during the day and shut off the lights that are not required to minimize heat. Maintenance is required to record indoor temperature and humidity percentage from various locations within the building daily and inform all departments of the heat contingency protocols to be implemented. The policy also required staff to receive annual education / information on prevention and management of heat related illness and hot weather plans.

Review of the home's Heat Contingency Protocols policy revealed three threshold levels that include Summer Practice, Intervention Alert, and Emergency Alert. Each threshold level had specific interventions for residents identified as being at high heat risk.

Observation specified date, revealed the lights were not turned off, the curtains in two identified resident rooms were not closed, the window on the south side corridor was left open. The humidity percentage was not recorded for any area in the home. In addition all staff did not receive annual education / information on prevention and management of heat related illness and hot weather plans. Interview with staff revealed not being aware of the threshold level during the course of the inspection.

Interview with the Director of Environmental Service confirmed the above action plan was not implemented following the issued heat alert. Interview with ADOC #114 confirmed annual education was not provided to staff in 2015. [s. 8. (1)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

On specified dates, Ministry of Health and Long-Term care ActionLine received two complaints. The complainants voiced a concern that air conditioning was not available in the home and the air temperature was very hot.

Observations on specified dates, revealed two out of four air conditioning/heat units on each of fourth, fifth, sixth floors and one unit on the third floor were not functioning, for a total of seven air conditioning units. In an interview with the Director of Environmental service stated that the dining room is a designated cooling area on each of the six floors.

Interview with resident #004 revealed he/she complained to the nursing staff and management team about the air conditioning/heat unit not functioning in an identified dining room on two occasions within six months period.

Interview with the Director of Environmental Services #101 confirmed being aware of the above identified equipment not functioning and indicated he/she was in the process of auditing all air conditioning / heat units in the home. [s. 15. (2) (c)]

WN #4: 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).

s. 20. (2) The licensee shall ensure that, if central air conditioning is not available in the home, the home has at least one separate designated cooling area for every 40 residents. O. Reg. 79/10, s. 20 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the written hot weather related illness prevention and management plan was implemented when required to address the adverse effects on residents related to heat.

On specified dates, Ministry of Health and Long-Term care ActionLine received two complaints. The complainants voiced a concern that air conditioning was not available in the home and the air temperature was very hot.

According to evidence based practice titled "The Guidelines for the Prevention and Management of Hot Weather Related Illness in Long Term Care, July 2012", developed by the Ministry of Health and Long Term Care, routine checks to assess indoor air temperatures and Humidex levels at varying times throughout the day should be implemented. The guidelines include direction to monitor outdoor air temperatures and Humidex levels to determine when indoor values needed to be evaluated. Once a Humidex value is between 30 and 39, which is a zone where most individuals would feel some discomfort, staff would need to be informed to enhance their monitoring of residents who were assessed at high to moderate heat risk. In some cases, monitoring of residents with specific health conditions would need to be monitored at a Humidex as low as 32.

The inspector observed on specified dates, that the long term care home was equipped with air conditioning units in the dining room and at the end of the North and South corridor on each floor. The resident bedrooms, the sitting area in front of nursing station

on each floor, and other area of the corridors are not air conditioned but supplied with fresh outdoor air which is dehumidified or tempered.

Review of the Air temperature log revealed the humidity records were not available to confirm what the values were inside of the home, either in any resident room, sitting area or any designated cooling area. The Director of Environmental Services was subsequently advised by the inspector to begin monitoring air temperatures and humidity levels.

On specified dates, the Director of Environmental Services evaluated the sitting area in front of the nursing station, resident's room and designated cooling areas as well as the corridors, and dining rooms on the fifth and sixth floors using a hygrometer. He/she recorded the air temperature and humidity percentage of each area and the readings were compared to the Humidex chart. The Humidex inside the identified resident's room was 34 on specified date. It was the hottest day out of the 3 days of this inspection. The designated cooling areas were also very similar with Humidex levels between 30 and 32. According to the records, air temperatures and humidity levels were not comfortable in designated cooling areas on specified dates.

Routine checks to access indoor Humidex levels were not implemented accordingly when required to address the adverse effects on residents related to heat. Discussion was held with the Administrator and Director of Environmental service regarding the on-going monitoring of certain areas of the building such as designated cooling areas and some key "hot spots" in the building that are occupied by residents. [s. 20. (1)]

2. The licensee has failed to ensure that, if central air conditioning is not available in the home, the home has at least one separate designated cooling area for every 40 residents.

On July 15 and 18, 2016, Ministry of Health and Long-Term care ActionLine received two complaints. The complainants voiced a concern that air conditioning was not available in the home and the air temperature was very hot.

The inspector observed on July 21, 22, and 25, 2016, that the long term care home was equipped with air conditioning units in the dining room and at the end of the North and South corridor on each floor. The resident bedrooms, the sitting area in front of nursing station on each floor, and other area of the corridors are not air conditioned but supplied with fresh outdoor air which is dehumidified or tempered.

Review of the Air Temperature Log revealed the humidity percentage records were not available to confirm what the values were inside of the home, either in any resident room, sitting area or any designated cooling area.

On July 22 and 25, 2016, the Director of Environmental Services evaluated the sitting area in front of the nursing station, resident's room and designated cooling areas as well as the corridors, and dining rooms on the fifth and sixth floors using a hygrometer. He/she recorded the air temperature and humidity percentage of each area and the readings were compared to the Humidex chart. The Humidex on July 22, 2016, which was the hottest day, was as follow:
- sixth floor cooling area/dining room 32,
- sixth floor sitting area in from of nursing station 34
- identified resident's room 34
- fifth floor cooling area/dining room 31,
- fifth floor sitting area in from of nursing station 33
- identified resident's room 34

Similar values were obtained on each floor on July 22, 2016. The designated cooling areas were also very similar with other area of the home with Humidex levels between 30 and 34 on July 22 and 25, 2016.

Interview with the director of environment services and the DON confirmed that dining rooms are the designated cooling area. The also confirmed that , air temperatures and humidity levels were not comfortable in designated cooling areas because the cooling areas have similar air temperature and humidity as other areas in the home. [s. 20. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home a response had been made to the person who made the complaint, indicating what the licensee had done to resolve the complaint.

On specified dates, Ministry of Health and Long-Term care ActionLine received two complaints. The complainants voiced a concern that air conditioning was not available in the home and the air temperature was very hot.

Interview with resident #003 revealed that the residents complained about the fifth and sixth floors being too hot during the Resident's Council meeting.

Review of the Residents' Council meeting minutes revealed the residents' complaint had not been documented in the meeting minutes.

Interview with Director of Resident Program #102 revealed on specified date, during the Residents' Council meeting, the residents had voiced concern related to the sixth floor dining room being hot and uncomfortable during meal time, the dining room was designated as cooling area. He/she confirmed the above concern was not forwarded to the appropriate department and a written response was not provided to the residents up to the inspection, which is 13 days later. [s. 101. (1) 3.]

Issued on this 9th day of August, 2016

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

Original report signed by the inspector.