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 # / No de registre	Type of Inspection / Genre d'inspection
Aug 16, 2018	2018_539120_0038	014568-18	Complaint

Licensee/Titulaire de permis

Better Life LTC Inc.
19 Richvalley Crescent RICHMOND HILL ON L4E 4C8

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

Maple Villa Long Term Care Centre
441 Maple Avenue BURLINGTON ON L7S 1L8

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): August 9, 2018

A complaint was received related to excessive heat in the home and various resident care concerns.

During the course of the inspection, the inspector(s) spoke with Administrator, Maintenance Manager, residents, registered staff, personal support workers, a family member and a housekeeper.

During the course of the inspection, the inspector toured the home, took air temperature and humidity readings, reviewed air temperature and humidity records, observed residents, reviewed hot weather and illness prevention management policy and procedures, clinical records and heat stress assessments.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
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 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).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for resident #001 set out clear directions to staff and others who provided direct care to the resident.

The written plan of care for resident #001 for 2018, relating to their transfer requirements included direction that staff provide two person extensive side by side assistance. On August 9, 2018, during an inspection, a logo identifying the same information was observed in a prominent location in the resident's bed area. At the same time, the resident was observed, with one staff member (#107), when they stood up and were assisted to use their assistive device. The care staff member identified themselves as a restorative care worker (#107) and stated that they alone could complete a single person assist with the resident based on their experience. All other staff were to follow the written plan of care and provide two person extensive side by side assistance.

According to the resident's family member, during the time of inspection, a personal support worker was observed assisting the resident, alone, from the washroom to the resident's chair. The family member reported that other personal support workers were transferring the resident alone over the last few months but did not provide the names of those workers. The Administrator was informed by the Inspector on the same date as to the information provided by the family member.

Discussion was held with a registered nurse (#108) on August 15, 2018, confirmed that the resident remained to be at risk of falls if they did not have two persons assisting them, but that staff #107, due to their experience, could continue to transfer the resident alone. This specialized care routine was therefore not clearly set out in the written plan

of care. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

A family member for resident #001, who visited the resident frequently, identified that the resident was observed sitting in their chair beside their bed on a number of occasions over the last several months and most recently on a specified date in July 2018, without access to the resident-staff communication and response system. The resident was observed by the Inspector sitting in their chair during the inspection, at approximately 1430 hours with the pull cord [connected to the activation station], was out of their reach, on the far side of their bed. According to the resident's written plan of care dated July 2018, the "call bell" was to be within reach of the resident while in their bed/chair. The requirement was added to the plan of care in March 2018.

The licensee therefore did not ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan. [s. 6. (7)]

WN #2: 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 has 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 Celcius (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 City of Burlington, 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, 2018, at which time designated cooling areas, which 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.

A complaint was received in July 2018, that a resident's room was uncomfortably warm between June 29 and July 5, 2018 and on July 21 and 22, 2018, and the common areas, such as dining rooms and sitting areas on the first floor were not effectively cooler than the resident's room. The complainant stated that two separate cooling systems were not functioning during the weekend of June 30 and July 1, 2018. The incremental unit at the end of the back short first floor corridor was off and a vent near the elevator in the long corridor was blowing warm air into the building, and not cool air like it normally did. No specific heat-related health effects were reported by the complainant other than the resident was uncomfortable, had difficulty breathing and could not get any relief. The complainant stated that they used a digital thermometer to measure the air temperature in the resident's room several times during the time periods noted above and reported it was over 30C.

According to the Maintenance Manager on August 9, 2018, air temperature and humidity readings were not recorded for designated cooling areas in the home. No records could

be provided to indicate whether the cooling areas were sufficiently cooler than the rest of the home or outdoors between June 29 and July 5, 2018. Only four different resident rooms were monitored and records provided included that the rooms were on average of 26C with a humidity of 65-65%. No Humidex was calculated, but based on the values provided, a chart was used to determine the Humidex, which was 32. None of the seven roof top air conditioning units that serviced the building were in disrepair or had malfunctioned during the first week of July 2018. However, the first floor long corridor was serviced by one roof top unit which was reported as having a tendency to freeze up when it ran for a long time to compensate for extreme temperatures and humidity outdoors. The Maintenance Manager explained that when the coil froze, he had instructed staff to shut down the unit until it thawed. When shut down, the cooling would cease, but the fan would continue to blow, which would have brought in outdoor air into the building without being conditioned. Confirmation was made with a housekeeper (#103) who worked on June 30, 2018, that the unit was shut off for several hours to thaw as they noticed the lack of cool air blowing into the corridor. With respect to the incremental unit at the end of the back short hall that the complainant noted was not running, it was noted to have a power button on the wall next to it and could have been shut off easily by anyone.

During the inspection, a tour of the various areas of the home were conducted, and air temperatures and humidity levels were taken with a digital hygrometer in the designated cooling areas, resident bedrooms and corridors between 1100 and 1300 hours. The hygrometer was placed away from heat and cooling sources and left for 10 minutes. A number of resident room windows were noted to be open, which would have affected the air cooling systems. Various different air conditioning units were noted in the building, all of which were functional. However, most of the units were known as stage one cooling units, which according to any manufacturer of commercial air conditioning units, are not efficient at de-humidification. The difference between a single stage and a two-stage unit is the type of compressor used. Single stage compressors are not very efficient when outdoor temperature and humidity levels are extreme and are only able to operate on one level of speed. A two-stage cooling system operates at two different speeds, and will adjust depending on the outdoor values and have better de-humidification. When relative humidity and air temperatures rise, the two-stage compressor responds, immediately adjusting its output to the higher speed to keep up with demand. The first floor dining room, lounge (near the Administrator's office) and the second floor dining room (area located on the north side) were equipped with incremental units (through the wall heating and cooling system for smaller zones). The first floor enrichment or activity room had one portable air conditioner mounted within a wall. The second floor dining room (area

located on the south side) was serviced by a roof top unit. Corridors were also air conditioned. The air temperatures in all of the spaces were 25-26C and 54-60% humidity (Humidex 29-30). Outdoor values were measured in the shade at 1315 hours and were 29C and 45% humidity (Humidex 33). Despite the cooling units operating, very little difference was noted between the cooling areas versus the resident rooms and corridors. Although the air temperatures were 3-4C cooler inside, the humidity levels were higher inside than outside.

During the inspection, the Administrator provided several policies related to hot weather management plans. The first was entitled "Prevention and Management of Hot Weather Related Illness in Long Term Care Homes", dated April 2017 and the second was entitled "Heat Alert Advisory", dated April 2017. Multiple other policies were provided which included specific staff roles and responsibilities and procedures. None of the policies or procedures included what areas of the home were considered designated cooling areas, what temperature the cooling areas needed to be maintained at to provide adequate cooling relief from other areas of the home or outdoors, how to calculate the Humidex and what actions to take if the designated cooling areas could not maintain adequate cooling. The policy related to maintenance roles and responsibilities included taking air temperatures and humidity levels in four different resident rooms each day between May 15 to September 30. The policy also included that the maintenance person was to inform the charge nurse if air temperatures exceeded 26C and humidity exceeded 40%. No information was included about a Humidex level or how to calculate it. The licensee's policy entitled "Heat Alert Advisory", included that residents would be encouraged to remain indoors if the Humidex reached 40. The Administrator was informed of the Ministry guidelines noted above with respect to monitoring resident symptoms beginning at an indoor Humidex of 30 and monitoring the designated cooling areas using appropriate hygrometers to determine whether the cooling units will provide adequate cooling when outdoor Humidex values rise over 30.

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 two plans provided by the licensee were 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 designated cooling areas within the building, at what point enhanced heat related interventions needed to begin 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)]

Issued on this 17th day of September, 2018

[redacted]

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

Original report signed by the inspector.