

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

| Original Public Report | |
|---|------------------------------------|
| Report Issue Date: July 20, 2023 | |
| Inspection Number: 2023-1355-0005 | |
| Inspection Type: Complaint | |
| Licensee: AXR Operating (National) LP, by its general partners | |
| Long Term Care Home and City: West Oak Village, Oakville | |
| Lead Inspector Sydney Withers (740735) | Inspector Digital Signature |
| Additional Inspector(s) | |

| INSPECTION SUMMARY |
|---|
| <p>The inspection occurred onsite on the following dates: June 29-30 and July 4-7, 10-12, 2023</p> <p>The following intake was inspected:</p> <ul style="list-style-type: none"> Intake 00089069 was related to cleanliness of the home, supplies in kitchen, staffing and laundry services. |

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

- Contenance Care
- Housekeeping, Laundry and Maintenance Services
- Food, Nutrition and Hydration
- Infection Prevention and Control
- Safe and Secure Home
- Staffing, Training and Care Standards

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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) (e)

The licensee has failed to ensure that the home's heat-related illness prevention and management plan included a protocol for appropriately communicating the plan to residents, staff, volunteers, substitute decision-makers, visitors, the Residents' and Family Councils of the home, and others where appropriate.

Rationale and Summary

The home's heat-related illness prevention and management plan indicated that an Alert Poster would be posted throughout the home to communicate their plan to residents, families and staff. The Alert Poster was reviewed and did not contain two of the four components as required under O. Reg. 246/22, s. 23 (2).

The Executive Director (ED) acknowledged that the procedure did not contain all components of the home's communication of their plan to the required individuals.

Sources: Procedure #CARE10-O10.09 "LTC - Heat-Related Illness" (reviewed March 31, 2023); Heat Stress Related Illness (Alert Poster); interview with ED. [740735]

WRITTEN NOTIFICATION: Air Conditioning Requirements

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 23.1 (2) (b)

The licensee has failed to ensure that in addition to the time period referred to in subsection (1), the air conditioning was in good working order in each of the areas described in that subsection.

Rationale and Summary

O. Reg. 246/22, s. 23.1 (1), identified that every licensee shall ensure that air conditioning was installed, operational and in good working order for the purpose of cooling the temperature during at least the period from May 15 to September 15 each year in every designated cooling area (DCA). The ED stated

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that the dining room was the DCA in each resident home area (RHA).

During an inspection of meal service, the inspector perceived the air temperature in one of the RHA dining rooms as hot and stuffy. When interviewed, a resident and substitute decision maker (SDM) stated that the temperature in the dining room was very warm. A registered practical nurse (RPN) identified that residents have recently preferred spending time in their bedrooms due to the warm temperatures in the common areas.

On two occasions during the inspection, the inspector measured the air temperature in the same dining room and both times it read above 26.0 degrees Celsius. The ED indicated that air temperatures in the DCAs were to be maintained within a comfortable range, between 22.0 and 26.0 degrees Celsius. Air temperature records for the home's DCAs were reviewed and indicated many days with temperatures reaching 27.0 degrees Celsius or higher.

The Regional Manager of Environmental Services (RMES) acknowledged that two of the home's seven rooftop units (RTU) were pending repairs and not properly serviceable. They confirmed that the RTU which serviced the dining rooms was not functioning. Inspection and estimation records from the home's heating, ventilation and air conditioning (HVAC) contractor indicated that both RTUs had lost refrigerant circuits and one of the two units had a failed compressor.

On the last date of inspection, one to two higher cooling capacity portable, window air conditioning units were observed to be installed and functioning in each of the five RHA dining rooms. The Environmental Services Manager (ESM) stated the plan was to install two higher capacity units per dining room once the electrical preparation was completed.

When the air conditioning was not in good working order, residents were placed at an increased risk of experiencing heat-related illness secondary to elevated temperatures in the home's DCAs.

Sources: Observation of RHAs; inspector temperature readings in a DCA; manual and automatic air temperature records (June-July 2023); HVAC inspection and estimation records; interviews with RMES, ESM, ED, RPN, SDM and resident. [740735]

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WRITTEN NOTIFICATION: Air Temperature

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 24 (3)

The licensee has failed to ensure that the air temperature required to be measured under subsection (2) was documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Rationale and Summary

O. Reg. 246/22, s. 24 (2), identified that air temperatures were to be measured and documented in every DCA, if there were any in the home. The ED stated that the dining room, a resident common area, was the DCA in each RHA. The home had five RHAs located across three floors.

During an inspection of meal service, the inspector perceived the air temperature in one of the RHA dining rooms as hot and stuffy. Air temperature records from June 2023 were reviewed and gaps were identified on two RHAs. The ED acknowledged that there were gaps in the air temperature records.

There was an increased risk of air temperatures above a comfortable level for residents being missed and components of the home's heat-related illness prevention and management plan not being implemented when temperatures were not measured or documented as required.

Sources: Manual and automatic air temperature records (June-July 2023); interviews with ED. [740735]

WRITTEN NOTIFICATION: Laundry Service

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 95 (1) (c)

The licensee has failed to ensure that as part of the organized program of laundry services, linens were maintained in a good state of repair, free from stains.

Rationale and Summary

The Ministry of Long-Term Care (MLTC) received concerns related to laundry services, specifically pertaining to the cleanliness of linens in the home. The clean linen supply on one RHA was observed in two storage areas and two resident rooms where staff had just changed the fitted and top sheets.

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Upon randomly selecting fitted and top sheets to observe in the storage areas, a large tear on one fitted sheet, and visible stains on one fitted sheet and two top sheets were observed. In one resident room, a large tear was noted in the centre of the fitted sheet and in the second resident room, staining was observed on the fitted sheet. The ESM acknowledged that the torn and stained linens were not in a good state of repair and should have been discarded.

Sources: Observations of care carts and two resident rooms on an RHA; photos 01-06; policy #ES D-15-05 "Soiled Linen Inspection" (reviewed February 1, 2022); interview with ESM. [740735]