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 2, 2018	2018_539120_0032	015969-18	Complaint

Licensee/Titulaire de permis

Rykka Care Centres GP Inc.
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

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

Arbour Creek Long-Term Care Centre
2717 King Street East HAMILTON ON L8G 1J3

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 5 and 6, 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 Administrator, Director of Care, Staff Development Co-ordinator, Food Services Manager, Environmental Services Supervisor, registered staff, personal support workers and residents.

During the course of the inspection, the inspector toured the building, reviewed the home's plan on managing hot weather related illness, took air and humidity temperatures, reviewed service reports for the air cooling system, the licensee's air and humidity temperature monitoring logs, resident clinical records related to hydration and hot weather symptom monitoring and observed the noon time meal on July 6, 2018.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).**

**s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

Findings/Faits saillants :

1. The licensee failed to ensure that the home had a dining and snack service that included, at a minimum, the following elements:

Providing residents with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

Resident #001, as per their current plan of care and through observation, was at high nutritional and hydration risk and not physically able to eat and drink independently and relied on personal assistance and encouragement to safely drink as comfortably and independently as possible. On the first date of inspection, at 1100 hours, the resident had a full glass of water (175 ml) at room temperature on a small table in their room. When the resident was offered the water by the inspector, they took a few sips. At 1345 hours, another full glass of water (125 ml) was in the room, next to the larger glass of water (175 ml) which was still partially full. On the second day of inspection, at 1040 hours, the resident's room included one 175 ml of glass of water, one 125 ml glass of chocolate milk 3/4 full and one bottle of a nutritional supplement drink that was more than 3/4 full. Each beverage was at room temperature. Between 1040 and 1115 hours, a staff member removed the chocolate milk, but the other beverages were left and the amount of liquid in each remained unchanged. Between 1115 and 1230 hours no staff member approached the resident to assist them to drink their beverages. At 1230 hours, staff member #107 took a meal tray to the resident's room, left a small glass of water (125 ml) and was back out of the room within 30 seconds. After the lunch time meal, at 1440 hours, the inspector was accompanied by staff #105 to the resident's room and observed

the same warm glass of water (175 ml), a small glass of water (125 ml) at room temperature and the same bottle of nutritional supplement. The resident was interviewed and confirmed that they refused their lunch time meal and when asked if a staff member asked them if they wanted a drink during the snack pass at 1400 hours the resident said no. The resident at that time was asked if they would like a drink and they said yes. Staff #105 was asked to get a new glass of water with ice. When staff #105 returned, the resident took sips from both the nutritional supplement and the glass of ice water.

A discussion was held with the Administrator and Staff Development Co-ordinator on July 6, 2018, regarding their expectations for adequate encouragement for residents who relied on staff assistance. Both identified that staff members needed to visit the resident routinely, not just during meals and snack time to offer encouragement, especially if the resident was at high nutritional and hydration risk.

The resident was therefore not provided with adequate encouragement to drink as comfortably and independently as possible. [s. 73. (1) 9.]

2. The licensee failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

On the second day of inspection, during the noon time meal, three residents (#002, #003 and #004) all required physical assistance with their meals and beverages according to their current plan of care and based on observations. All three residents were seated at the same table. Beverages were placed on the table at 1159 hours and plates of food were placed in front of all three residents at approximately 1220 hours. Resident #004 was assisted with their meal by staff #106 who also tried to attempt to assist resident #002 at the same time. However resident #002 was non-responsive and appeared to be sleeping. Resident #003 was not assisted at all. By 1245 hours no one had attempted to assist resident #002 or #003. By 1320 hours, residents #002 and #003 had not received any assistance with their meals.

The licensee therefore did not ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has a dining and snack service that includes, at a minimum that residents are provided with personal assistance and encouragement to safely eat and drink as comfortably and independently as possible and that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

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. (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 if central air conditioning was not available in the home, there was at least one separate designated cooling area available for every 40 residents.

As of May 31, 2018, the home's central air conditioning system was not functioning to it's full capacity and the entire building was affected. New components were required but were not readily available for installation until July 6, 2018. Some portable fans were purchased to circulate the air, however the fans did not offer any relief. Heat alerts were issued for the Province of Ontario beginning on June 17, 2018, when the Humidex (temperature plus humidity) values approached or exceeded 40. 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. Values over a Humidex of 35 were experienced on June 17, 18, 29, 30, July 1-5, 2018, at which time the designated cooling areas, which included the dining rooms and common spaces, were not available to residents. During an inspection on July 5, 2018, the indoor and outdoor

values were almost equal with a slight difference of approximately 5 degrees Celcius (C). Air temperature and humidity values were recorded by the inspector using a hygrometer and infrared thermometer in several resident rooms on the third floor and in the dining rooms and lounges on third and second floors. Air temperatures and humidity levels were also recorded by maintenance staff throughout June and July 2018, for resident bedrooms, however, the values were not documented in common spaces, including those in the basement (wellness centre/chapel and media room).

On July 5, 2018, the outdoor Humidex was 39 at 1000 hours according to Environment Canada. The air temperature was 29C with a humidity of 63%. Inside the home, on the third floor, an identified resident room was 28C and 64% humidity for a Humidex of 36. The dining room was 26C with 52% humidity. After lunch, it was 27.2C and 64%. The room temp and humidity increased due to occupied space and use of steam tables for the lunch meal. In another identified resident room on the third floor, the air temperature was 28C with 60% humidity. In the second floor dining room, at 1145 hours, the temperature was 26C with a humidity of 54%. The measured values and feeling of discomfort between the resident rooms, corridors, dining rooms or lounges was similar. Complaints were reported to the inspector from a family member and residents who resided on the third floor and some residents were observed to be quite uncomfortable during the inspection. Various staff members reported that the basement common spaces were slightly cooler, however no temperature or humidity values were recorded by the licensee to verify the differences.

The licensee therefore did not provide a separate designated cooling area for every 40 residents when the central air conditioning was not available. [s. 20. (2)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of a breakdown of major equipment or a system in the home no later than one business day after the occurrence of the incident, followed by the required report.

The licensee did not submit a critical incident report to the Director after learning that a major system in the home was not going to be functional for more than six hours. The home's air conditioning system was out of service between May 31 and July 6, 2018, and affected the entire building (except the kitchen). The malfunctioning units were responsible for cooling the resident home areas on each floor. This included the common spaces such as dining rooms and lounges, which were required to be the designated cooling areas for all residents. The weather conditions began to change on June 17, 2018, when extreme heat warnings were issued for the Province of Ontario. The air conditioning system for the home was not able to provide adequate cooling areas for the residents. [s. 107. (3) 2.]

Issued on this 8th day of August, 2018

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

Original report signed by the inspector.