Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 25, 2019	2019_539120_0030	016310-19, 016602-19	Complaint

Licensee/Titulaire de permis

955464 Ontario Limited
3700 Billings Court BURLINGTON ON L7N 3N6

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

Millennium Trail Manor
6861 Oakwood Drive NIAGARA FALLS ON L2E 6S5

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): September 17, 18, 2019

The following intakes were completed during this inspection;

016310-19 related to the housekeeping program and heat stress management interventions and excessive heat in the home;
016602-19 related to heat stress management interventions and excessive heat in the home.

During the course of the inspection, the inspector(s) spoke with the Administrator, Housekeeping/Laundry Manager, Maintenance Manager, Therapeutic Services Manager, registered staff, maintenance, housekeeping and recreation staff.

During the course of the inspection, the inspector toured four home areas, including random resident rooms, washrooms and common areas, reviewed indoor air temperature records, heat related illness management policies and procedures, housekeeping routines, audits and schedules and cooling system preventive and remedial maintenance records.

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

During the course of this inspection, Non-Compliances were issued.
- **1 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	Légende 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. 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 failed to ensure that the hot weather related illness prevention and management plan was developed in accordance with evidence-based practices.

On July 19, 2012, the Acting Director for the Performance Improvement and Compliance Branch of the Ministry of Health and Long Term Care posted a notice informing all Administrators about the "Guidelines for the Prevention and Management of Hot Weather-Related Illness in Long Term Care, July 2012" as an evidence-based practice to follow, along with other sources. The guideline includes how to monitor the internal building environment for both humidity and temperature when outdoor conditions exceed a temperature of 25 degrees Celcius(C). How to calculate the Humidex and interventions to reduce the heat and humidity in the building once it approaches a Humidex of 30 or greater are included along with measures to reduce heat related illness. 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.

Several complaints were received in August 2019, for a specific week, that residents' rooms were very hot and the common areas, such as dining rooms and lounges were not effectively cooler than the rest of the home, especially when occupied for meals or activities. No specific heat-related health effects were reported by the complainants other than the residents sweated profusely, could not sleep and could not get any relief, especially at night. One complainant regarding resident #201 was initially given permission to have a portable air conditioner installed but was later informed that it was

not permitted. When the air conditioner was in place, the family member reported that the thermometer on the unit read 86F (30C) prior to turning it on. The same family member reported finding the resident's windows and blinds open, allowing direct sun and humidity into the room.

Multiple staff members who were interviewed about the heat during the summer months reported that they did not notice much of a difference between the corridors and the dining rooms or lounge areas. Staff #015 showed the inspector a photo of a thermometer they took of the home area they worked in during the specified week in August 2019, indicating a temperature of 81F (27C). However, maintenance staff #004 reported that the dining rooms and lounges were cooler and that there was some difference between the spaces. The perception of how the environment felt to each person was quite different depending on time of day and how much physical activity was being exerted. In order to eliminate perception, humidity and temperature logs were requested for the common areas or designated cooling areas for review.

The Humidex for the region of Niagara Falls was over 30 for six days in August 2019. During these times, the licensee would have been required to initiate their hot weather management plan to ensure that the building was adequately monitored, that cooling equipment and supplies were readily available and that resident care was appropriate for the conditions.

During the inspection, the Administrator provided their policy and procedures related to managing the building and residents during hot weather entitled "Prevention and Management of Hot Weather Related Illness" dated August 2012. Under the subtitle of "Process for monitoring internal temperatures", the direction included checking air temperatures in non-air conditioned common areas and at least one resident room. It did not include any direction to take relative humidity readings, how to calculate the Humidex, to take readings in designated cooling areas and to ensure that their designated cooling areas were effectively cooler than the rest of the building or exterior. No direction was included to monitor resident rooms who were at high risk of heat related illness, to determine whether or not the resident required to be relocated or have an air conditioner installed in their room, as per their policy. The family member for resident #201 reported to staff that the room was unbearably hot (30C) and that the resident could not sleep. The resident was assessed as high risk for heat related illness. The resident's clinical records did not include whether any interventions were taken and whether the resident's environment was verified to be over 30C. A list identifying all residents at increased risk of heat related illness was required to have been provided to each nurses'

station, however two home area registered staff did not receive or have access to such a list.

Under staff roles and responsibilities, no direction was included for any staff member to ensure that windows were monitored to limit the amount of humidity entering the building.

Under the subtitle of "Preparation and Planning",maintenance staff were to have portable cooling equipment available on standby during "hot spells" where possible. Maintenance staff #004 reported that they had numerous portable A/C units available at a nearby location, ready for use when needed. However, staff #004 did not receive any requests from any nursing staff to install the units. The policy did not include any guidance as to what communication was necessary between maintenance and nursing staff on acquiring the units, where they would be installed, when certain high risk residents would warrant having an A/C unit in their room and how this intervention would be managed. Nursing staff who were interviewed did not know about the option of requesting a portable A/C unit and thought they were not permitted. According to the Administrator, their admission agreement included a statement that portable air conditioners were not allowed. According to many staff members, no additional A/C units were brought into the home to offset the high temperatures in the dining rooms and resident rooms, especially for resident rooms that were at high risk for heat related illness.

Residents #201 and #202, who were both assessed for heat risk, each had the exact generic interventions listed in their plan of care related to managing heat related illness. Resident #201 was assessed as high risk for heat related illness and had medical risk factors that increased the potential for heat related illness. Resident #202 was assessed as moderate risk with advanced age and use of certain medications. The licensee's policy did not include any guidance as to specifically what interventions were required for each resident who was at risk related to their unique health condition during times of excessive heat. Under the section entitled "Resident Risk Assessment and Process", no guidance was provided to ensure that nursing staff identify interventions that are specific to the individual resident's health status instead of generic prevention concepts.

The licensee did not ensure that the hot weather related illness prevention and management plan was developed in accordance with evidence-based practices. [s. 20. (1)]

2. The licensee failed to ensure that at least one separate designated cooling are was available for every 40 residents.

During a specified week in August 2019, two complaints from family members were made to the Ministry of Long Term Care regarding the excessive heat conditions in the home and their concerns for the well being of residents. During this time period, the Humidex for the region of Niagara Falls was over 30 on six days in August 2019. The Humidex is calculated by plotting the relative humidity and air temperature on a graph to determine a value. A value of 30 or higher is considered uncomfortable and would necessitate monitoring of residents for heat related symptoms and ensuring that the designated cooling areas in the home were maintained at a temperature that was lower than surrounding areas and that could effectively reduce or mitigate symptoms of heat-related illness.

The long term care home has five home areas, each equipped with an air conditioned dining room, lounge and activity room to accommodate all of the residents living within the home area (32 residents). According to families and nursing staff, the dining rooms and lounges were not noticeably cooler than the corridors or resident rooms in two identified home areas on the west side. Staff reported that they and the residents were sweating profusely during the summer months when the Humidex was high. According to the maintenance staff, several cooling system components were not functioning efficiently as of June 2019, and had to be replaced. The parts were not replaced until mid July and mid September 2019. Other issues affecting the comfort conditions of all three floors (on the west side) included the fact that the controllers (thermostats) and sensors for the first floor and second floor common areas were not located in the same zones, but several rooms away or on a different floor. The temperature was therefore not reflective of the zone and had to be regulated manually by maintenance staff.

The designated cooling areas in the home were not monitored. No records were maintained for either the temperatures or the humidity in these areas. Records that were provided included temperatures values only for two resident rooms and an area near each nurse's station. No records could be provided to confirm that the designated cooling areas were cooler or more comfortable than that of surrounding areas.

The licensee did not ensure that at least one separate designated cooling are was available for every 40 residents. [s. 20. (2)]

Issued on this 26th day of September, 2019

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

Original report signed by the inspector.