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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 23, 2013	2013_189120_0063	H-000377/000468/000486-13	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

VALLEY PARK LODGE
6400 VALLEY WAY, NIAGARA FALLS, ON, L2E-7E3

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 20, 2013

During the course of the inspection, the inspector(s) spoke with the administrator, director of care and maintenance personnel regarding maintenance services, the home's hot weather management program and critical incident reporting.

During the course of the inspection, the inspector(s) toured resident rooms, common areas, shower/bathing area and dining room, took air temperatures, tested the functionality of the incremental units, windows and blinds.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. (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 :

The licensee could not establish whether their designated cooling area(s) were in fact cooler than the surrounding environment between July 15 and July 19, 2013. The home has a dining room that can accommodate all of their residents or a minimum of 40 residents. Other smaller cooling areas in the home include the quiet room, tv room, activity room and sitting area near the nurse's station. However none of these smaller rooms can accommodate all 40 residents at one time.

Between July 15 & 19, 2013, according to Environment Canada, the outdoor air temperature in Niagara region was between 26 and 34.8C with a humidex level between 29 and 48. A humidex above 45 is considered dangerous for heat stroke and a level between 30-39 will cause some discomfort with a small chance of some heat stress symptoms.

On July 17, 2013, five incremental cooling units failed to operate, 3 in the dining room, one in the quiet room and one in the activity room. On July 17, 18 and 19, 2013, corridor temperatures were recorded by staff and identified to be 29-32C with a humidex between 37 and 45. However, temperatures in the various designated cooling spaces or rooms were not taken to determine if they were below 29C or a humidex of 37 so that residents could obtain relief.

According to the Director of Care, residents were however monitored for signs and symptoms of heat stress during the week of July 15, 2013 and no one became ill. [s. 20(2)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

The licensee has not ensured that interior areas of the home were maintained in good repair. On September 20, 2013, approximately 7 windows located in resident rooms could either not be locked, closed or opened. The windows were noted to be casement style with a crank at the bottom sill. The casement windows which could not close shut by using the crank were required to be pushed shut from the outside or pulled closed by hand or make shift implement. The maintenance person reported that they have not been able to locate replacement parts for the window hardware. A current plan of action was not available at the time of the visit. [s. 90(1)(a)]

Issued on this 23rd day of September, 2013

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

B. Susnik