Ontario

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

Inspection Report under the
Fixing Long-Term Care Act, 2021

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
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Original Public Report

Report Issue Date September 26, 2022
Inspection Number 2022_1440_0002
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Schlegel Villages Inc.

Long-Term Care Home and City
The Village of Humber Heights

Lead Inspector
Rodolfo Ramon (704757)

Additional Inspector(s)
Helina Leung (741076)

Inspector Digital Signature
Rodolfo A Ramon Alvarez
Digitally signed by Rodolfo A Ramon Alvarez
Date: 2022.10.18 10:48:59 -04'00'

The inspection occurred on the following date(s): August 29-31, September 1, 2, 5-9, 2022

The following intake(s) were inspected:

- #014411-22 (complaint) related to dining services
- #012565-22 (complaint) related care services
- #011983-22 related to (complaint) recreation activities
- #006731-22 related to falls (CIS #2957-000011-22)

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Recreational and Social Activities
- Resident Care and Support Services

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#01 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 6(10)(b)

The licensee has failed to ensure that resident #001's plan of care was reviewed and revised when the care set out in the plan was no longer necessary.

Rationale and Summary

During a meal observation conducted by the inspector, resident #001 was observed eating their meal without assistance.

According to resident #001's plan of care, resident required assistance with eating. Registered Practical Nurse #104 verified that the plan of care was not up to date and needed to be modified in accordance to resident #001's current care needs.

The plan of care was updated prior to the completion by RPN #104.

Sources: Observations, interview with RPN #104, and resident #001's care plan.

Date Remedy Implemented: September 8, 2022 [704757]

WRITTEN NOTIFICATION FLTCA, 2021 S. 6(7)

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6(7)

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan.

Rationale and Summary

The Ministry of Long-Term Care (MLTC) received a complaint related to multiple areas of concern including improper care of resident #002. A Critical Incident System (CIS) report for the same concern was submitted by the home to the MLTC.

On an identified date, the complainant witnessed a type of care being provided to resident #002.

The Assistant General Manager (AGM) verified that an internal investigation was completed by the long term care home which indicated that care was not provided to resident #002 as specified in their plan of care. This placed resident #002 at potential risk of not having their needs met.

Sources: CIS report # 2957-000032-22, interview with the AGM, resident #002' care plan, the licensee's investigation notes.

[704757]

WRITTEN NOTIFICATION FLTCA, 2021 S. 28(1)(1)

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)

Non-compliance with: FLTCA, 2021 s. 28(1)(1)

The licensee has failed to ensure that a report is made to the director immediately upon suspicion of improper or incompetent treatment of resident #002.

Rationale and Summary

A concern was brought forward to the licensee where resident #002 was provided type of care by a staff. As a result of the care provided, a CIS report was submitted seven days later to the director in relation to this incident.

A review of the licensee's complaints record indicated that the long term care home's management team became aware one day after the incident. The AGM acknowledged that the CIS report was not immediately submitted to the director.

Sources: CIS report # 2957-000032-22, interview with the AGM, licensee's complaint response form.

[704757]

WRITTEN NOTIFICATION O. REG. 79/10 S. 107(3.1)(b)

NC#04 Written Notification pursuant to O. Reg. 79/10, s. 107(3.1)(b)

Non-compliance with: O. Reg. 79/10 s. 107(3.1)(b)

The licensee failed to ensure that the Director was notified within three business days after a resident sustained an injury and resulted in hospitalization and a significant change in their condition.

Rationale and Summary

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The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report related to an incident involving resident #003 where the resident sustained an injury that resulted in significant change in their health status.

Resident #003 sustained an injury, as a result, they were transferred to the hospital for further assessment. According to the progress notes, the home's Charge Nurse spoke with a hospital nurse and was advised that resident #003 would be going through a significant change in their health status.

The CIS report was submitted four business days after the incident that resulted in a significant change in the resident's health condition. The AGM acknowledged that the CIS Report was reported late.

Sources:

CIS Report 2957-000011-22, resident #003's progress notes, hospital records and interviews with RPN #110 and AGM #107.

[741076]