Ontario

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

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

Toronto District
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Original Public Report

Report Issue Date: March 13, 2024	
Inspection Number: 2024-1440-0001	
Inspection Type: Complaint Critical Incident	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: The Village of Humber Heights, Etobicoke	
Lead Inspector Lisa Salonen Mackay (000761)	**Inspector Digital Signature**
Additional Inspector(s) Rajwinder Sehgal (741673)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 22, 23, 26, 27, 29, and March 4, 5, 6, 7, 2024

The following intake(s) were completed in this Critical Incident (CI) inspection:

- Intake: #00100740/CI#2957-000040-23 and Intake: #00101785/CI# 2957-000041-23 were related to late reporting;
- Intake #00105417/CI#2957-000001-24 and Intake #00107730/CI#2957-000005-24 were related to infection control and prevention;
- Intake #00106303/CI# 2957-000003-24 and Intake #00107033/CI#2957-000004-24 were related to falls prevention and management.

The following intake was completed in this complaint inspection:

- Intake #00102706 was related to food, nutrition, and hydration.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that there was a written plan of care that set out clear directions regarding resident's fluids consistency preparation.

Rationale and Summary:
A resident's plan of care indicated that the resident required a specific fluid

consistency. In addition, the recipe to prepare the thickened fluids was also posted in the area for staff to follow, however, the recipe indicated different preparation instructions than the ones listed in the care plan.

Food Service Manager (FSM) acknowledged that the care plan did not specify the right measurements and the recipe posted in the area for preparing the specific fluid consistency for the resident was correct. They acknowledged that the resident's plan of care did not provide clear directions to staff for preparation of a specific fluid consistencyfor the resident.

Failure to provide clear directions in preparing of a specific fluid consistency for the resident increased the resident's risk of choking.

Sources: Resident's clinical records, interviews with Dietician, FSM, Director of Care (DOC) and other staff.
[741673]

WRITTEN NOTIFICATION: DIETARY SERVICES AND HYDRATION

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 15 (2)
Dietary services and hydration
s. 15 (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied.

The licensee failed to ensure the resident was provided with correct diet texture that was safe for the resident.

Rationale and Summary:
A resident's care plan indicated that they were at high nutrition risk and required a specific texture diet and fluids at a specific consistency.

During a meal service, the resident was served a meal as per their dietary requirements. The resident's Power of Attorney (POA) observed small pieces of un-pureed food in the meal and reported to Registered Practical Nurse (RPN).

RPN acknowledged that the meal, contained small thin pieces of un-pureed food.

Failure to follow the process of serving meals according to residents' diet orders resulted in the resident being placed at risk for choking.

Sources: Resident's clinical records, interview with staff RPN, DOC, FSM and other staff.
[741673]

WRITTEN NOTIFICATION: REPORTING CRITICAL INCIDENTS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act using the Critical Incident System (CIS) report.

Rationale and Summary:
The home was declared in a confirmed outbreak in October and November, 2023 by Toronto Public Health (TPH). The CIS reports were both submitted one day after it was declared.

The Infection Prevention and Control (IPAC) Lead was aware that the confirmed outbreaks were required to be reported immediately and confirmed the Director was not notified immediately.

Failure of the home to immediately inform the Director did not place residents at risk.

Sources: CIS 2957-000040-23 and 2957-000041-23, and interview with IPAC Lead.
[000761]