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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 12, 2017	2017_637500_0008	004466-16, 009535-16, 020486-16, 022258-16, 025793-16, 026284-16, 029137-16, 034652-16	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

THE VILLAGE OF HUMBER HEIGHTS
2245 Lawrence Avenue West ETOBICOKE ON M9P 3W3

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

NITAL SHETH (500), SIMAR KAUR (654), THERESA BERDOE-YOUNG (596)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 22, 23, 24, 27, 28, 29, 30, 31, April 3, 4, 5, 6, 7, 10, 11, 12, 13, 18, 19, 20, 21, 24, 25, 26, 27, 28, May 1, 2, 4, 5, 2017.

During the course of the inspection, the inspector(s) spoke with General Manager (GM), Assistant General Manager (AGM), Director of Nursing (DON), Assistant Director of Nursing (ADON), Resident Assessment Instrument (RAI) Coordinators, Registered Dietitian (RD), Kinesiologist, Physiotherapist, Neighborhood Care Coordinators, Maintenance Technician, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Care Aides (PCAs), Private Care Givers, Residents, and Family members.

During the course of this inspection, inspectors observed resident’s care, staff to resident interaction, reviewed resident health care records and home’s records.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents were fully

respected and promoted: every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

A review of the Critical Incident System (CIS), dated 2016, revealed that the GM identified two PCAs providing care to resident #005 in the common area without protecting his/her privacy, while reviewing of the video footage of the common home areas. The GM found two PCAs woke resident #005 to provide care in the lounge area in the presence of another resident. PCAs removed the resident’s clothing and left him/her naked in the lounge while they provided care to the resident. The care did not align with the Residents’ Bills of Rights to provide dignity and privacy during care. PCAs left the resident after the care was provided and failed to cover the resident with a blanket to make him/her comfortable.

A review of the resident’s plan of care revealed the resident is highly cognitive impaired and required extensive to total assistance.

A review of the video footage provided by the home, revealed that on two different occasions the resident was provided care by staff in the common lounge area of the home, in the presence of another resident.

A review of the video footage dated, 2016, revealed that two PCAs removed the resident's clothing and provided care to the resident, leaving him/her without any clothing, in the presence of another resident.

A review of the video footage dated, 2016, revealed that one PCA provided incontinence care to the resident in the presence of another resident.

The inspector could not interview staff involved in the incident because PCAs were not available for interviews.

Interview with PCA #141, #143, RPN #142, and #160 revealed that resident’s privacy should be protected by providing care in their rooms, with closed door, or pulling out a curtain in their rooms. It is not acceptable to provide care in the common areas of the home.

A review of the investigation notes, and an interview with AGM, and GM confirmed the above mentioned incident and indicated that the resident’s privacy should be protected and the resident should have been treated with dignity and respect. As a result of the

investigation the home took disciplinary measured towards staff involved in the incident. [s. 3. (1) 8.]

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 following rights of residents are fully respected and promoted: every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Record review of CIS revealed that the home reported that resident #015 had sustained a fracture related to a fall.

Record review of resident #015's progress notes revealed that the resident was transferred to the hospital in 2016. Record review of the resident's falls incident reports revealed the resident fell and sustained an injury.

Record review of the resident's post falls follow up dated, 2016, revealed that it was

incomplete.

Record review of the resident's X-ray report from the hospitalization revealed an injury to the resident.

Interview with RPN #131 revealed that resident #015's post falls analysis was incomplete and he/she signed off on it, but could not remember why it was not completed fully.

Interview with the DOC revealed that a post falls assessment should have been completed after the resident fell in 2016. [s. 49. (2)]

2. Record review of resident #019's Falls Risk Assessment dated, 2017, indicated the resident high risk for falls.

Record review of the resident's plan of care reflected falls interventions including monitoring, ensuring resident wears foot wear safe for ambulation, high low bed, and hip protector.

Record review of falls incident reports for resident #019 dated January 29, 2017, indicated that the resident was found on the floor in his/her room in the fetal position and sustained an injury. The resident was transferred to hospital and returned the same day with a treatment. Further review of resident #019's falls incident reports revealed that on another day in 2017, the resident was found on the floor of his/her room and did not sustain any injuries.

Record review of the resident's two post falls follow up reports dated, 2017, revealed that the analysis and referral sections were not completed.

RPN #155 offered no explanation as to why he/she did not complete resident #019's post falls follow up reports in their entirety for both falls in 2017.

Interview with the DOC revealed that RPN #155 should have fully completed resident #019's post falls follow up reports on the days mentioned above. [s. 49. (2)]

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 when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident under subsection (1), (3) or (3.1) within 10 days of becoming aware of the incident, or sooner if required by the Director, and a report was made in writing setting out the following with respect to the incident: a description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

Record review of CIS revealed that the home reported that resident #015 had sustained an injury related to a fall.

Record review of the CIS did not include a description of the incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. MOHLTC requested an update in 2016, to include the above mentioned information and the resident's history of falls for the past six months, including dates and injuries sustained. The CIS had not been updated at the time of this inspection.

Interviews with the Neighborhood Care Coordinator (NCC) #124 revealed that he/she submitted the CIS, and doesn't know why it wasn't updated with the requested information.

Interviews with the DOC and AGM revealed that they don't know why the CIS was not updated and it was the responsibility of the NCC, ADOC or DOC to update the CIS. [s. 107. (4) 1.]

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 Director is informed of an incident under subsection (1), (3) or (3.1) within 10 days of becoming aware of the incident, or sooner if required by the Director, and a report is made in writing setting out the following with respect to the incident: a description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident, to be implemented voluntarily.

Issued on this 12th day of June, 2017

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

Original report signed by the inspector.