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

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 # / No de registre	Type of Inspection / Genre d'inspection
Jun 5, 2018	2018_484646_0005	001900-18	Complaint

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

IVY LAM (646)

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): March 21, 22, 23, 26, 27, 28; April 3, 4, 5, 9, 10, 11, 12, 13, 16, 2018.

This inspection was done concurrently with Resident Quality Inspection (RQI) inspection #2018_484646_0004 / 004736-18.

A Written Notification related to LTCHA, 2007, S.O. 2007, C.8, s. 3. (1) 1., identified in concurrent inspection #2018_484646_0004 (Log # 004736-18) will be issued in this report.

A Written Notification related to LTCHA, 2007, S.O. 2007, C.8, s. 6. (10) (b), identified in concurrent inspection #2018_484646_0004 / (Log # 004736-18) will be issued in this report.

During the course of the inspection, the inspector(s) spoke with Acting General Manager (AGM), Director of Nursing (DON), Assistant Directors of Nursing (ADON), Resident Assessment Instrument (RAI) Coordinators, Neighborhood Care Coordinators, Infection Prevention and Control Lead (IPAC lead), Registered Dietitian (RD), Food Service Aides, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeepers, and Residents.

During the course of this inspection, inspectors observed residents' care, staff to resident interaction, dining room services, kitchen and servery food production, stock supply rooms, reviewed resident health care records and home's records.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Nutrition and Hydration
Pain
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.

5 WN(s)
1 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity, was fully respected and promoted.

This inspection is related to complaint #001900-18, related to multiple concerns for resident #036 including staff's use of personal phone in the resident's room.

Interview with resident #036 revealed that staff did not treat them with respect and dignity. Resident #036 indicated that Personal Support Worker (PSW) #130 did not treat them with respect when the staff answered their personal cell phone in the resident's room on an identified date.

Review of voice recording #1673, on an identified date, revealed that a cellphone had rung, and a PSW had answered the phone call while the PSW was still in the resident's room.

Review of the home's policy, titled 'Personal Phone Calls,' in the Human Resources Manual, Code of Conduct section, Tab 04-18, last updated December 21, 2017, revealed that: 1. Personal phone calls may be made by team members during their break/lunch times with the permission of the department manager. 2. Emergency phone calls may be made with the permission of the department manager/supervisor. 3. All other phone calls should be made by the team member on his/her break using their own personal cell phones.

Interview with PSW #130 revealed that it was them on the recording, and that the PSW

was unsure if it was an emergency, and had taken the call on their personal phone. PSW #130 further revealed that personal phones should not be used during work.

Interview with neighbourhood coordinator (NC) #120 revealed that the home's process is that the PSW should inform the NC if they were expecting an emergency call, and should not take the call in the resident's room, as per the home's policy.

Interview with the Acting General Manager (AGM) revealed that the staff should take phone calls when they are on their breaks or at lunch, and should inform their supervisors if it is an emergency call before they take the call. The AGM further revealed that the staff did not follow the home's Personal Phone Calls – Code of Conduct, and that the action was not respectful to resident #036, and had not ensured resident #036's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity, was fully respected and promoted. [s. 3. (1) 1.]

2. This inspection is related to complaint #001900-18, related to multiple concerns for resident #036 including staff leaving resident undressed in front of a housekeeper and an NC.

Interview with resident #036 revealed that staff did not treat them with respect and dignity when staff left them exposed and undressed in front of a housekeeper and the NC. Resident #036 indicated that PSW #143 had left the resident undressed in front of housekeeper #140, and PSW #122 had left the resident undressed in front of NC #120, and these actions disregarded the resident's rights to privacy and dignity.

A. Review of voice recording #1639 revealed that on an identified date, PSW #143 was conversing with resident #036 and left the resident's room. Several minutes later, PSW #143 and a second staff member were heard to enter the resident's room. The second staff member asked why resident #036 was not covered, and resident #036 asked PSW #143 to cover resident #036. Review of progress notes did not reveal any documentation of the incident.

Interview with housekeeper #140 revealed that they were the second staff who entered the resident's room, as they were called to provide cleaning in the resident's room. When housekeeper #140 entered the room, they found the resident uncovered and undressed.

Interview with PSW #143 revealed that they were the PSW who entered the first and the second time, but they had not covered the resident the first time, because they thought

the resident needed the housekeeper to clean their room. On their second entry with housekeeper #140, the PSW noticed that the resident was not covered. PSW #143 further revealed that the PSW should have covered the resident for the resident's dignity and privacy before asking for another staff to come.

B. Review of voice recording #1656 revealed that on another identified date, a staff was heard speaking with the resident, and a second staff was heard to come in, and the second staff asked why the resident was not covered.

Interview with PSW #122 revealed that they were the first staff conversing with the resident. The PSW further revealed that on the day of the incident, they had gone in to provide resident #036 with an identified care. The PSW #122 further stated that resident #036 appeared upset and the PSW had not offered to cover the resident that day before NC #120 came in and saw the resident undressed and uncovered.

Interview with NC #120 revealed that they had come in saw that resident was undressed, and got an identified piece of covering for the resident.

The NC further revealed that for both incidents, their expectation is for staff to recognize when the resident is uncovered, to cover the resident to provide dignity for the resident. Interviews with NC #120 and the AGM revealed that the resident's dignity was not fully respected and promoted during the two incidents above. [s. 3. (1) 1.]

3. This inspection is related to complaint #001900-18, related to multiple concerns for resident #036 including staff leaving resident undressed in front of a housekeeper and an NC.

Interview with resident #036 revealed that staff did not treat them with respect and dignity. Resident #036 indicated that staff members had responded to them in a disrespectful manner on multiple occasions.

Review of Voice Recording #1610 revealed that on an identified date, resident #036 had provided instructions to a staff member regarding how to care for a number of identified personal items, assistance with identified care equipment, and requests for items that the resident required for their care. The PSW communicated that there were other residents waiting for the PSW. After 20 minutes, when the PSW communicated again that there are residents waiting for the PSW, the PSW also stated to the resident that this is why

nobody wants to come in as the resident calls, and that resident #036's requests were not necessary.

Interview with resident #036 revealed that the staff spoke to the resident in a disrespectful manner.

Interview with PSW #130 revealed that they were the staff in the recording. The PSW further revealed that their response to the resident that day may appear disrespectful to the resident.

Interview with NC #120 and the AGM revealed that PSW#130 did not speak to resident #036 with courtesy and respect in a way that fully recognizes their individuality and respects their dignity during the described interaction above. [s. 3. (1) 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 following rights of residents are fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out: (c) clear directions to staff and others who provide direct care to the resident.

This inspection was initiated related to complaint #001900-18, related to multiple concerns for resident #036, including nutrition and hydration care, related to staff not providing the expected portion as per the resident's care plan.

Interview with resident #036 revealed that they were not provided an identified nutrition intervention as per their planned care and per discussion with NC #120. The resident further clarified that they expected nutrition intervention at breakfast.

Review of the a Personal Care Aide (PCA) service binder on an identified home area revealed that the resident may request for the identified nutrition intervention. Review of the resident's current care plan on PointClickCare (PCC) did not reveal any direction to staff related to providing the resident with the identified nutrition intervention.

Interview with Food Service Aide #144 revealed that the identified nutrition intervention for resident #036 meant it was to be provided at lunch but not at breakfast. FSA #144 also revealed that the instructions on the care plan did not specify which meal the resident should receive the identified nutrition intervention.

Interview with PSW #143 revealed that the resident requests for the identified nutrition intervention at all meals.

Interview with the Registered Dietitian (RD) revealed that the care plan did not provide clear directions for the staff to the staff for what the identified nutrition intervention meant, including the meal the intervention should be provided at and what items to provide. [s. 6. (1) (c)]

2. The licensee has failed to ensure that residents were reassessed and the plan of care reviewed and revised at least every six months and at any other time when: (b) the resident's care needs change or care set out in the plan is no longer necessary.

This inspection was initiated related to complaint #001900-18, regarding multiple concerns for resident #036, including nutrition and hydration care.

Review of resident #036's nutrition care plan on pointclickcare (PCC) and the PSW service binder revealed that the resident required an identified type of eating assistance.

Review of resident's current MDS revealed that the resident required a different type of identified eating assistance.

Interviews with the resident, PSWs #143 and #145, and the Registered Dietitian (RD) showed that the type of eating assistance identified on the MDS was correct.

Interview with the RD indicated that the resident's written care plan should have been updated when the resident's eating assistance care needs changed. [s. 6. (10) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was: (b) complied with.

As per O. Reg. 79/10, s. 30 (1), every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under s. 48 of this Regulation: 1.There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

O. Reg. 79/10, s. 48 (1), states that every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: 4. A pain management program to identify pain in residents and manage pain.

This inspection is related to complaint #001900-18, related to multiple concerns for resident #036 including PSWs not reporting to nurses when resident voiced they had pain.

Review of Voice Recording #1687 revealed that on an identified date, resident #036 had stated that they experienced pain on an identified area of their body, and PSW #143 had apologized. Resident #036 further stated that the staff should be more careful when helping the resident, and that PSW #143 should report this to the nurse. PSW #143 responded that they would report this.

Review of resident #036's progress notes did not reveal any mention of the incident on

the identified date above. No pain assessment was found related to the resident's pain of the identified area of the body on the above identified date.

Review of the home's policy, titled "Pain Management Program" in the nursing manual (section: Care), revised date December 19, 2017, approved date January 10, 2018, revealed:

The registered team will complete and document a pain assessment with distress-related personal expression or facial grimacing when report from resident, family, team member volunteers that pain is present.

The PSW will recognize and report on a daily basis any resident verbalizations and personal expressions indicative of discomfort.

Interview with PSW #143 revealed that during this incident, the PSW may have injured the resident's identified area of the body while assisting the resident with turning the resident with an identified care. The PSW further revealed that RPN #141 was working at the time, and that PSW #143 had informed RPN #141.

Interview with RPN #141 revealed that the RPN did not recall PSW #143 having informed the RPN of the incident, and that there was nothing documented in the progress notes regarding the incident, and pain assessment was not done.

Interview with NC #120 revealed that staff did not follow the home's pain policy related to reporting and assessment when resident #036 complained of pain to PSW #143. Interview with AGM revealed that it was the home's expectation for the staff to follow the pain policy to when the resident complains of pain to the staff, and that the staff did not comply with the pain policy for the above-mentioned incident. [s. 8. (1) (a),s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

This inspection was initiated related to complaint #001900-18, related to multiple concerns for resident #036, including dignity, choice, and privacy, related to staff refusing to offer or provide an identified type of bathing method on the resident's shower/bath days.

Review of Voice Recording #1638 revealed that on an identified day, it was resident #036's shower/bath day, and the resident had asked a staff member for an identified type of bathing method, but the staff member replied that they preferred to give the resident a second identified type of bathing method. The resident responded that they would like the first type of identified bathing method. The staff member responded that it is either that the resident wants the second identified bathing method, or they don't. The staff member further stated they are not refusing to give the resident the second identified type of bathing method because it is their shower/bath day.

Review of the resident's bathing care record on the identified date, showed that the resident had refused bathing care.

Interview with PSW #174 showed that they were the one on the recording, and had offered to provide resident #036 with the second type of identified bathing method instead. PSW #174 further stated that they knew the resident wanted the first type of bathing method but that the PSW preferred and insisted on giving the resident the second type of bathing method. The PSW further stated that the resident was not offered the first type of bathing in the end, and the resident had refused the second type of bathing method. PSW #174 revealed that they had not provided the resident bathing care

by resident #036 method of choice that day.

Interview with NC #120 revealed PSW #174 may have offered and insisted on providing the resident with the second type of bathing method, but that the staff should ensure to offer the resident's choice if the resident had refused to the second identified type of bathing method and had requested on the first type of bathing method instead.

Interviews with NC #120 and the AGM revealed that it is the home's expectation for staff to offer residents with their preferred bathing method of choice, and that PSW #174 had not provided resident #036 bathing care by the method of choice of resident #036 on the day of the incident. [s. 33. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the programs included a weight monitoring

system to measure and record with respect to each resident, weight on admission and monthly thereafter.

This inspection is related to complaint #001900-18, related to multiple concerns for resident #036, including the resident not being weighed on a regular basis.

In an interview, resident #036 stated that the home had not offered to weigh the resident monthly, and the resident does want their weight taken.

Review of resident #036's weight history revealed that the resident's last weight was taken on an identified date, and no other weight for the resident was recorded for an identified number of months. Review of the progress notes during the identified number of months did not reveal documentation that resident #036 had refused to have their weight taken.

Review of the home's policy, titled 'Weight & Height Monitoring' in the Nursing Manual, Care section, Tab 04-76, last updated March 25, 2017, revealed that:
- The PCA is responsible for completing the resident's weight by the seventh of each month
- The resident will be weighed on their first bath/shower day of the month

Interviews with PSWs #131, #138, #143, and #174 showed that it is the home's process for residents to be weighed in the first week of the month, and to reapproach and reoffer if the resident refuses.

PSW #138 revealed that they have provided an identified bathing type for the resident but had not weighed the resident that day as it was not the beginning of the month. Interviews with PSWs #131 and #174 also revealed that they have provided an identified bathing type for resident during this time period.

Interview with RPN #141 revealed that the home's process for taking residents' weights is that residents are weighed in the first seven days of the month, usually on the resident's first bath day. However, if the resident refused their bath, the RPN was unsure if staff would still be offering to weigh the resident. The RPN revealed that if the resident refuses to be weighed at that time, the PSWs should inform registered staff, and the registered staff should document the resident's refusal in the progress notes. The RPN revealed that the PSWs have not reported to the RPN that resident #036 has been

refusing to have their weight taken. The RPN further revealed that PSWs should be offering to weigh the resident even if it is not the resident's shower day. RPN #141 revealed that no weights have been recorded for resident #036 since an identified date.

Interview with NC #120 revealed that it is the home's expectation for all residents to be weighed by the seventh of the month, and if the resident refuses, staff are expected to document the refusal on the pointofcare (POC) and registered staff should document in the progress notes, and to offer to weigh the resident again. NC #120 further revealed that the staff have not been doing so for resident #036.

Interview with the AGM revealed that the home did not ensure the weight monitoring system to measure and record the monthly weights for resident #036 was done. [s. 68. (2) (e) (i)]

Issued on this 18th day of June, 2018

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

Original report signed by the inspector.