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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 31, 2019	2019_705109_0002	010652-18, 016654-18	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

SUSAN SQUIRES (109), ANGIE KING (6445)

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): January 17, 18, 21, 22, 23, 24, 25, 2019

The following Critical Incident System intakes were inspected during this Critical Incident System Inspection:
Log # 010652-18, related to alleged abuse
Log # 016654-18, related to falls.

During the course of the inspection, the inspector(s) spoke with Acting Assistant General Manager, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Behavioural Support Lead (BSO), Neighbourhood Coordinator, Physiotherapist (PT), Kinesiologist, Nurse Practitioner (NP), Assistant Director of Care (ADOC), residents, and family members.
During the course of the inspection the inspectors(s) conducted health record reviews, observed the care activities, reviewed policies, and staff schedules.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **1 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	Légende 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

A critical incident was submitted to the Ministry of Health and Long-Term Care regarding an incident that occurred on a specified date, in which resident #002 had tripped over a specified piece of equipment and fallen down. The resident sustained injuries which required emergency treatment at the hospital.

Record review of the plan of care for a specified date, and three falls risk assessments, indicated that resident #002 was identified to be at risk for falls. Record review of the progress notes for an identified date, and the falls assessment for the same date indicated that the resident was wandering in the corridor when the staff heard a loud bang. While the progress note stated that the actual fall was not witnessed, it stated that it appeared that the resident must have tripped over the opened specified piece of equipment as they were found lying on the floor beside the equipment.

During separate interviews staff members #123, #124, and #125 each told the inspector that the resident tripped over the specified piece of equipment because it was sitting in the corridor and left open.

Observations conducted on a different home area on a specified date and time revealed a specified piece of equipment to be opened and sitting on the floor in front of the nursing area and adjacent to the resident lounge area. Several residents were in wheelchairs in the lounge. There were no residents walking at the time of the observations, however there were ambulatory residents on the unit.

During an interview staff #115 stated that the identified equipment should be stored elsewhere and immediately ordered the staff to move it to a safe area.

This finding was discussed with staff #101 regarding the home failing to ensure that the environment was safe from trip hazards which caused a resident to fall and sustain an injury and posed risk to other residents. Non-compliance is warranted. [s. 5.]

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 home is a safe and secure environment for its residents, to be implemented voluntarily.

Issued on this 31st day of January, 2019

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

Original report signed by the inspector.