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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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
May 31, 2019	2019_641665_0008 (A1)	014600-18, 031445-18, 002598-19, 003043-19, 004099-19, 005304-19, 005661-19	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

Amended by JOY IERACI (665) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

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Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Change in the compliance due date for CO #001 and CO #002.

Issued on this 31st day of May, 2019 (A1)

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

Original report signed by the inspector.

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*

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

Amended by JOY IERACI (665) - (A1)

Amended 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): April 12, 16, 17, 18, 23, 24, 25, 26, 29, 30 and May 1, 2, 3, 2019. Off site May 7 and 8, 2019.

The following intake logs were inspected:

- Follow Up Log #002598-19 related to plan of care;

- Log #014600-18/CIS #2957-000023-18 and #004099-19/CIS #2957-000010-19 related to abuse;

- Log #003043-19/CIS #2957-000007-19 and 005304-19/CIS #2957-000011-19 related to abuse and neglect;

- Log #005661-19/CIS #2957-000012-19 related to falls management;

- Log #031445-18/CIS #2957-000042-18 related to an injury of unknown cause.

During the course of the inspection, the inspector(s) spoke with the Assistant General Manager (AGM), Director of Nursing Care (DNC), Assistant Director of Nursing Care (ADNC), Neighbourhood Coordinators (NC), Resident Assessment Instrument - Minimum Data Set (RAI-MDS) Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Care Aides (PCAs) and residents.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.
- **7 WN(s)**
- **2 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2019_705109_0001	665

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 provision of the care set out in the plan of care was documented.

The home submitted a CIS report on an identified date in 2018, related to an incident that caused an injury of unknown cause to resident #007. The CIS report indicated that the resident was transferred to hospital, and was diagnosed with an identified injury and received treatment.

At the time of the inspection, the resident was no longer a resident in the home.

A review of the written plan of care at the time of the critical incident indicated that the resident required a specified number of staff members to assist with five identified care areas. Review of the documentation survey report for the month the critical incident occurred, indicated that there were no documentation of the care that was provided on a specified shift eight days prior to the critical incident, and, seven days prior to the critical incident, care was not provided by the specified number of staff members for one identified care area.

Review of the staffing schedule indicated that PCA #124 was the assigned staff on the specified shift on the two days mentioned above.

In an interview, PCA #124 indicated that resident #007 required the specified

number of staff members to assist the resident with the care areas mentioned above. The PCA also indicated that it was their responsibility to document the care they provided for the resident in point of care (POC). The PCA reviewed the documentation survey report and stated that they had documented incorrectly and, had assistance with the specified number of staff members for one of the identified care area noted above. PCA #124 stated that they did not document the care provided for the resident on the other day they worked with the resident.

In an interview, the DNC indicated that PCAs are expected to document the care they provided to residents. The DNC reviewed the documentation survey report and acknowledged that the care provided to resident #007 was not documented. [s. 6. (9) 1.]

2. The home has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

The home submitted a CIS report for an allegation of staff to resident physical abuse towards resident #004 on an identified date in 2019. The CIS report indicated that a PCA entered the resident's room at an identified time to get the resident ready for bed, however, the resident refused and said no, but the PCA continued to provide care.

Review of the written plan of care at the time of the CIS indicated that the sleep pattern focus was revised eight months ago, informing staff that resident #004 preferred to go to bed at the identified time.

In an interview, PCA #106 indicated they were the assigned PCA for resident #004 and provided care to the resident at the time of the critical incident. The PCA stated that they usually put the resident to bed at the identified time mentioned above. The PCA went into the resident's room before the identified time to provide an identified task for the resident and to prepare the resident for bed.

In an interview, PCA #104 indicated that resident #004 had a bed time routine and would use a specified communication device between two specified times to get ready for bed. PCA #104 stated that the resident would say no if a PCA gets them ready for bed before the specified times. The PCA indicated that the resident was cognitively aware, was aware of their bedtime routine, had a clock in their room

and would tell the PCAs when they wanted assistance to get ready for bed. On the day of the critical incident, PCA #104 indicated that they had observed PCA #106 enter the resident's room before the specified times and did not observe the specified communication device activated by the resident. The resident and PCA #106 were observed coming out of the room with the resident wearing their night clothing. In the interview, PCA #104 stated that the resident's plan of care did not indicate that the resident would use the identified communication device between two specified times when they were ready for bed.

In an interview, RPN #105 who worked at the time of the critical incident, indicated that resident #004 was cognitively aware. The RPN stated that the resident preferred to go to bed between two specified times and will use an identified communication device when the resident was ready for bed. When a PCA goes in too early, the resident will not accept care and will say no. The RPN reviewed the plan of care and indicated that the preferred bedtime was not an accurate reflection of the resident's preferences regarding their bedtime routine. RPN #105 stated that the plan of care should have been revised to reflect the care needs of the resident.

In an interview, the DNC reviewed resident #004's plan of care and indicated that the plan of care should have been revised for resident #004 to reflect their bed time routine.

3. The home has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective.

The home submitted a CIS report for a fall that caused injury to resident #006 on an identified date and time. The CIS report indicated that the resident was found on the washroom floor by RPN #128 with an injury. The resident was assessed and had five areas of altered skin integrity. Resident #006 was transferred to hospital and had an identified diagnosis. The resident passed away in hospital two days after the critical incident.

Review of the clinical records indicated that the resident was at risk of falls. A review of the falls incident reports in the assessment tab in point click care (PCC) indicated that the resident had four falls over a span of five months prior to the critical incident. The resident sustained injuries as a result of the four falls.

Review of the written plan of care included interventions to manage the resident's falls. The falls focus indicated that the resident is at risk for falls related to significant injury on an identified date in 2018, and two specified characteristics the resident exhibited. There were nine identified interventions to manage the resident's falls.

In interviews, PCA #126 and RPN #128 indicated that resident #006 was at a high risk for falls and ambulated with an identified mobility device with assistance. The PCA and RPN indicated that the resident did not use a specified communication device when they needed to ambulate and use the washroom. The PCA further stated that they would find the resident in the washroom on their own without calling for assistance during a specified shift, and would continually remind the resident to call for assistance to go to the washroom, however, the resident would exhibit one of the two specified characteristics mentioned above.

In the interview, RPN #128, indicated that the one of the identified intervention was not an effective intervention to manage the resident's falls. The RPN stated that the resident did not call for assistance to go to the washroom during the specified shift, when four out of the five falls occurred.

In an interview, ADNC #127 who is the home's falls lead indicated they had reviewed and revised the plan of care for resident #006 on two identified dates in 2018, over a span of two months, to manage the resident's falls. The ADNC indicated that five months prior to the critical incident, they had reviewed and revised the plan of care for directing staff to implement an identified intervention, and, another identified intervention one month later. In the interview, the ADNC stated that the resident exhibited one of the specified characteristics and did not call for assistance even when the identified intervention noted above was implemented five months prior. They acknowledged that this identified intervention was not effective in managing resident #006's falls, and the home did not revise the plan of care when the plan of care was reviewed.

In an interview, the DNC indicated that resident #006 exhibited the two specified characteristics noted above. The DNC acknowledged that the identified intervention mentioned above was not an effective intervention to manage the resident's falls. The home failed to ensure that resident #006 was reassessed and the plan of care reviewed and revised when the identified intervention had not been effective.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee has failed to ensure that residents were protected from abuse by anyone.

For the purpose of the definition of abuse, physical abuse in subsection 2 (1) of the O. Reg. 79/10, means the use of physical force by anyone other than a resident that causes physical injury or pain.

The home submitted a CIS report for an allegation of staff to resident physical abuse towards resident #004 for an incident that occurred on an identified date in 2019. The CIS report indicated that a PCA entered the resident's room at an identified time to get the resident ready for bed, however, the resident refused and said no, but the PCA continued to provide care. The report stated that the resident was hit by the PCA during care and had complained of pain to a specified area of

the body.

A review of the progress notes in PCC one day later indicated the resident informed the unit nurse that somebody had hit the specified area of the body noted above and was painful upon movement. A review of the resident's electronic medication administration record (EMAR) for an identified month in 2019, indicated that the resident received 11 doses of their as needed analgesic for pain to the specified area of the body noted above on 10 identified dates in the same month.

A review of the progress notes in PCC indicated that the nurse practitioner (NP) assessed the resident five days after the critical incident, and observed an area of altered skin integrity to the specified area of the body, and two other identified observations

A review of the home's investigation notes indicated that PCA #106 went into the resident's room to get the resident ready for bed at an earlier time than the resident's bed time routine. While in the washroom, the resident became resistive to care when the PCA started to provide care. The resident exhibited physically responsive behaviour during care and the PCA grabbed a specified part of the resident's body and put it on another specified area of the body mentioned above.

In an interview, PCA #104 indicated that resident #004 had a bed time routine and would use a specified communication device between two specified times to get ready for bed. PCA #104 stated that the resident would say no if a PCA gets them ready for bed before the specified times. The PCA indicated that the resident was cognitively aware, was aware of their bedtime routine, had a clock in their room and would tell the PCAs when they wanted assistance to get ready for bed. On the day of the critical incident, PCA #104 indicated that they had observed PCA #106 enter the resident's room before the specified time and did not observe the specified communication device activated by the resident. In the interview, PCA #104 stated they had heard resident #004 crying while PCA #106 was in the room providing care. The resident and PCA #106 were observed coming out of the room with the resident wearing their night clothing.

In an interview, PCA #106 indicated that they had resigned from the home after the incident with resident #004. The PCA stated that on the day of the critical incident, the resident exhibited physically responsive behaviour during care in the

washroom. PCA #106 stated that they took a specified part of the resident's body and had put it on the specified area of the body mentioned above. The PCA denied the allegation of physical abuse towards resident #004.

During an interview on an identified date and time, resident #004 indicated that a staff member was rough with them during care in the washroom. The resident indicated that they did not want their clothes changed and had an altercation with the staff member when they were hit on the specified area of the body by the staff. Resident #004 stated that they had pain to the area after the incident.

In interviews, NC #107 and the DNC indicated that the home conducted an investigation and concluded that physical abuse had occurred towards resident #004 by PCA #106. The DNC stated that the resident sustained altered skin integrity to the specified area of the body and had complained of pain as a result of the incident. Both NC and DNC stated that PCA #106 had a history of discipline related to resident abuse and had resigned after the critical incident.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

The licensee has failed to ensure that without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy was complied with.

A review of the home's prevention of abuse and neglect policy #Tab 04-06, with an effective date of November 1, 2018, indicated under policy on page one, "All team members are required to report any suspicions, incidents, or allegations of neglect and/or abuse immediately to the Director as well as any supervisor or any member of the leadership team for further investigation, and to follow Section 24-Mandatory Reports".

The home submitted a CIS report on an identified date in 2019, related to an allegation of staff to resident abuse towards resident #010. The CIS report indicated that the substitute decision maker (SDM) of resident #010 reported to NC #130 that the resident felt scared and was concerned that a staff member had been rough with them. The SDM indicated that they had reported to RPN #100 seven days ago, that they were concerned about the resident and that someone was scaring them.

A review of the progress notes in PCC dated 14 days prior to the critical incident, by RPN #100 indicated that resident #010's SDM informed the RPN that someone scared the resident. The RPN told the SDM that there were no issues reported by the PCA.

A review of the home's investigation notes indicated that the home considered the progress note by RPN #100 noted above, as an allegation of abuse and had a discussion with the RPN on two identified dates in 2019.

In an interview, NC #130 indicated that the staff must report to their supervisor

any allegation of suspected abuse. The NC stated they initiated an investigation the day that the CIS report was submitted to the MOHLTC, for the allegation of abuse and indicated that RPN #100's progress note mentioned above, was an allegation of suspected abuse. The RPN did not report the SDM's allegation of abuse to their supervisor as per the home's prevention of abuse and neglect policy.

In an interview, RPN #100 indicated that they did not consider what the SDM reported to them as an allegation of abuse. The RPN stated in hindsight, they should have reported the allegation to their supervisor.

In an interview, the DNC indicated that the home considered what the SDM reported to RPN #100 on January 21, 2019, as suspected abuse and it was the RPN's duty under mandatory reporting to have reported the allegation. The DNC acknowledged that RPN #100 did not report the allegation of abuse immediately to their supervisor as per the home's prevention of abuse and neglect policy.

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 licensee's written policy to promote zero tolerance of abuse and neglect of residents was complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The home has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

The home submitted a CIS report on an identified date in 2018, related to an incident that caused an injury of unknown cause to resident #007. The CIS report indicated that during care, it was observed that resident #007 had an area of altered skin integrity to a specified area of the body. The resident was transferred to the hospital and, was diagnosed with an identified injury.

The home conducted an investigation regarding the circumstances surrounding the injury. Review of the investigation notes indicated that four days prior to the critical incident, PCAs #120 and #122, had observed an area of altered skin integrity to the same specified area of the body noted above, and, reported it to RPN #123. RPN #123 assessed the area of altered skin integrity. The investigation notes also indicated that RPN #123 recalled that PCAs #120 and #122 reported the area of altered integrity and had assessed the area but did not document in the resident's chart.

Review of the clinical records in PCC did not locate any documentation or assessment of the altered skin integrity that was discovered four days prior to the critical incident. .

In interviews, PCAs #120 and #122 indicated that when they provided care to the resident during an identified shift four days prior to the critical incident, they observed the area of altered skin integrity on resident #007. They stated that they reported the altered skin integrity to RPN #123 who looked at the area.

At the time of the inspection, RPN #123 was not employed by the home and attempts to contact the RPN were not successful.

In interviews, RPN #111 and ADNC #121 who is the home's skin and wound lead indicated it is the home's process for a weekly skin observation assessment to be completed upon discovery of altered skin integrity. The ADNC reviewed the weekly skin observation assessments in PCC and acknowledged that an assessment was not completed for resident #007's altered skin integrity that was discovered four days prior to the critical incident.

In an interview the DNC acknowledged that resident #007 did not receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment upon discovery of the altered skin integrity by PCAs #120 and #122 and RPN #123.

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The home has failed to report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

The home submitted a CIS report #2957-000011-19 on an identified date in 2019, related to an allegation of staff to resident neglect towards resident #010. Review of the CIS report indicated it was amended nine days later, stating the home's investigation was still pending. At the time of the inspection, there were no other amendments made to the CIS report as to the outcome of the home's investigation.

In an interview, NC #130 indicated that they had submitted the CIS report to the Director. The NC stated that CIS reports had to be amended to provide the outcome of any investigation that had been completed. The NC reviewed the CIS report and indicated that they had overlooked amending the CIS report with the outcome of the investigation.

In an interview, the DNC acknowledged that the home had failed to ensure that the Director was provided the results of every investigation undertaken. [s. 23. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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 section 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. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The home has failed to 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 section 48 of this Regulation: 4) The licensee shall keep a written record relating to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A review of the home's annual 2018 evaluation of their skin and wound program did not include the date of the evaluation and the names of the persons who participated in the evaluation.

In an interview, ADNC #121, indicated that the evaluation was completed on December 31, 2018, and acknowledged that the date of completion and the participants were not included in the evaluation.

In an interview, the DNC reviewed the 2018 skin and wound evaluation and agreed that the date and the participants of the evaluation were not included as per legislative requirements. [s. 30. (1) 4.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

The home submitted a CIS report, on an identified date in 2018, related to staff to resident abuse. A review of the CIS report indicated that the CIS was amended two months later, with the outcome of the home's investigation.

In an interview, the AGM indicated that the investigation was completed six days after the CIS was submitted. The AGM stated that the final report to the Director was missed and was not submitted within 10 days of the alleged incident as per legislative requirements.

2. The home submitted a CIS report on an identified date in 2019, related to an allegation of staff to resident abuse towards resident #010. Review of the CIS report indicated the report was amended 18 days after the initial report was submitted with the outcome of the home's investigation, the status of the resident and the staff members involved.

In an interview, NC #130 indicated that they had submitted the CIS report to the Director. The NC stated that CIS reports had to be amended within 10 days, at any time when new information was received and to provide an update and/or outcome of any investigation that had been completed. The NC reviewed the CIS report and indicated that they did not amend the CIS report within 10 days.

In an interview, the DNC acknowledged that the home had failed to ensure that a preliminary report to the Director was provided within 10 days for the CIS report.

Issued on this 31st day of May, 2019 (A1)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	Amended by JOY IERACI (665) - (A1)
Inspection No. / No de l’inspection :	2019_641665_0008 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	014600-18, 031445-18, 002598-19, 003043-19, 004099-19, 005304-19, 005661-19 (A1)
Type of Inspection / Genre d’inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 31, 2019(A1)
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	The Village of Humber Heights 2245 Lawrence Avenue West, ETOBICOKE, ON, M9P-3W3
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Pauline Dell'Oso

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To Schlegel Villages Inc., you are hereby required to comply with the following order (s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must be compliant with s.6 (10)(c) of the LTCHA, 2007.

Specifically the licensee must:

1) Ensure that any resident that is at high risk for falls have their plan of care reviewed and revised to ensure that their interventions are effective in managing their falls.

2) Develop an auditing process to ensure that residents who have had multiple falls in the last six months, have their plan of care reviewed to ensure their interventions to manage falls are effective. The home is required to maintain a documentation record of the audits, the dates the audits were conducted, who performed the audits and an evaluation of the results.

Grounds / Motifs :

1. The home has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective.

The home submitted a CIS report for a fall that caused injury to resident #006 on an

identified date and time. The CIS report indicated that the resident was found on the washroom floor by RPN #128 with an injury. The resident was assessed and had five areas of altered skin integrity. Resident #006 was transferred to hospital and had an identified diagnosis. The resident passed away in hospital two days after the critical incident.

Review of the clinical records indicated that the resident was at risk of falls. A review of the falls incident reports in the assessment tab in point click care (PCC) indicated that the resident had four falls over a span of five months prior to the critical incident. The resident sustained injuries as a result of the four falls.

Review of the written plan of care included interventions to manage the resident's falls. The falls focus indicated that the resident is at risk for falls related to significant injury on an identified date in 2018, and two specified characteristics the resident exhibited. There were nine identified interventions to manage the resident's falls.

In interviews, PCA #126 and RPN #128 indicated that resident #006 was at a high risk for falls and ambulated with an identified mobility device with assistance. The PCA and RPN indicated that the resident did not use a specified communication device when they needed to ambulate and use the washroom. The PCA further stated that they would find the resident in the washroom on their own without calling for assistance during a specified shift, and would continually remind the resident to call for assistance to go to the washroom, however, the resident would exhibit one of the two specified characteristics mentioned above.

In the interview, RPN #128, indicated that the one of the identified intervention was not an effective intervention to manage the resident's falls. The RPN stated that the resident did not call for assistance to go to the washroom during the specified shift, when four out of the five falls occurred.

In an interview, ADNC #127 who is the home's falls lead indicated they had reviewed and revised the plan of care for resident #006 on two identified dates in 2018, over a span of two months, to manage the resident's falls. The ADNC indicated that five months prior to the critical incident, they had reviewed and revised the plan of care for directing staff to implement an identified intervention, and, another identified intervention one month later. In the interview, the ADNC stated that the resident exhibited one of the specified characteristics and did not call for assistance even

when the identified intervention noted above was implemented five months prior. They acknowledged that this identified intervention was not effective in managing resident #006's falls, and the home did not revise the plan of care when the plan of care was reviewed.

In an interview, the DNC indicated that resident #006 exhibited the two specified characteristics noted above. The DNC acknowledged that the identified intervention mentioned above was not an effective intervention to manage the resident's falls. The home failed to ensure that resident #006 was reassessed and the plan of care reviewed and revised when the identified intervention had not been effective.

The severity of this issue was determined to be a level three as there was actual harm as resident #006 sustained an identified injury. The scope of this issue was isolated to resident #006. The home had a level three compliance history with one or more related non compliance in last the 36 months with the same area of non-compliance that included:
- Voluntary Plan of Correction (VPC) issued under inspection #2018_484646_0004, March 8, 2018. (665)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 15, 2019(A1)

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s.19(1) of the LTCHA, 2007.

Specifically the licensee must:

1. Ensure that resident #004 is protected from abuse by staff.

2. Review the plan of care for resident #004 to ensure their bedtime routine reflects the care needs of the resident.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

For the purpose of the definition of abuse, physical abuse in subsection 2 (1) of the O. Reg. 79/10, means the use of physical force by anyone other than a resident that causes physical injury or pain.

The home submitted a CIS report for an allegation of staff to resident physical abuse towards resident #004 for an incident that occurred on an identified date in 2019. The CIS report indicated that a PCA entered the resident's room at an identified time to get the resident ready for bed, however, the resident refused and said no, but the PCA continued to provide care. The report stated that the resident was hit by the PCA during care and had complained of pain to a specified area of the body.

A review of the progress notes in PCC one day later indicated the resident informed

the unit nurse that somebody had hit the specified area of the body noted above and was painful upon movement. A review of the resident's electronic medication administration record (EMAR) for an identified month in 2019, indicated that the resident received 11 doses of their as needed analgesic for pain to the specified area of the body noted above on 10 identified dates in the same month.

A review of the progress notes in PCC indicated that the nurse practitioner (NP) assessed the resident five days after the critical incident, and observed an area of altered skin integrity to the specified area of the body, and two other identified observations

A review of the home's investigation notes indicated that PCA #106 went into the resident's room to get the resident ready for bed at an earlier time than the resident's bed time routine. While in the washroom, the resident became resistive to care when the PCA started to provide care. The resident exhibited physically responsive behaviour during care and the PCA grabbed a specified part of the resident's body and put it on another specified area of the body mentioned above.

In an interview, PCA #104 indicated that resident #004 had a bed time routine and would use a specified communication device between two specified times to get ready for bed. PCA #104 stated that the resident would say no if a PCA gets them ready for bed before the specified times. The PCA indicated that the resident was cognitively aware, was aware of their bedtime routine, had a clock in their room and would tell the PCAs when they wanted assistance to get ready for bed. On the day of the critical incident, PCA #104 indicated that they had observed PCA #106 enter the resident's room before the specified time and did not observe the specified communication device activated by the resident. In the interview, PCA #104 stated they had heard resident #004 crying while PCA #106 was in the room providing care. The resident and PCA #106 were observed coming out of the room with the resident wearing their night clothing.

In an interview, PCA #106 indicated that they had resigned from the home after the incident with resident #004. The PCA stated that on the day of the critical incident, the resident exhibited physically responsive behaviour during care in the washroom. PCA #106 stated that they took a specified part of the resident's body and had put it on the specified area of the body mentioned above. The PCA denied the allegation of physical abuse towards resident #004.

During an interview on an identified date and time, resident #004 indicated that a staff member was rough with them during care in the washroom. The resident indicated that they did not want their clothes changed and had an altercation with the staff member when they were hit on the specified area of the body by the staff. Resident #004 stated that they had pain to the area after the incident.

In interviews, NC #107 and the DNC indicated that the home conducted an investigation and concluded that physical abuse had occurred towards resident #004 by PCA #106. The DNC stated that the resident sustained altered skin integrity to the specified area of the body and had complained of pain as a result of the incident. Both NC and DNC stated that PCA #106 had a history of discipline related to resident abuse and had resigned after the critical incident.

The severity of this issue was determined to be a level three as there was actual harm as resident #004 sustained altered skin integrity and had pain. The scope of this issue was isolated to resident #004. The home had a level three compliance history with one or more related non compliance in last the 36 months with the same area of non-compliance that included:
- Voluntary Plan of Correction (VPC) was issued under inspection 2018_484646_0004, March 8, 2018.
(665)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 15, 2019(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 31st day of May, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by JOY IERACI (665) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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Service Area Office / Bureau régional de services : Toronto Service Area Office