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
May 13, 2019	2019_641665_0009	004757-19	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

JOY IERACI (665)

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): April 18, 23, 24, 25, 26, 29, and 30, 2019 and May 1, 2 and 3, 2019.

Intake Log #004757-19 related to resident leave of absences and plan of care was inspected.

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), residents and substitute decision maker (SDM).

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Medication
Personal Support Services
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint through the ACTIONline on an identified date in 2019, by resident #005's SDM related to plan of care concerns.

In an interview, the complainant indicated that the resident developed an area of altered skin integrity and had received medication to treat the altered skin integrity. The complainant stated that the physician ordered an identified medication for the altered skin integrity and, the registered staff continued to administer the medication when the altered skin integrity had resolved.

A review of the physician's orders indicated a medication order on an identified date in 2019, to treat the altered skin integrity until resolved. The medication was discontinued nine days after it was ordered.

A review of the weekly skin observation tool located an assessment that was completed six days after the identified medication was ordered. RPN #115 indicated in the assessment that the altered skin integrity on resident #005 had resolved.

A review of the electronic medication administration record (EMAR) for an identified month in 2019, indicated that the resident received 12 doses of the identified medication over a period of three days when the altered skin integrity had resolved.

In an interview, RPN #115 indicated that they had assessed the resident's altered skin integrity noted above and did not observe any altered skin integrity on the resident. The RPN stated that they did not follow the directions of the identified medication order and should not have administered the medication.

In an interview, the DNC indicated that the identified medication should not have been administered when the resident's altered skin integrity had resolved. The DNC acknowledged that the home failed to ensure that resident #005's identified medication was administered in accordance with the directions for use specified by the prescriber.

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (2) The licensee shall ensure that each resident receives assistance, if required, to use personal aids. O. Reg. 79/10, s. 37 (2).

Findings/Faits saillants :

The licensee has failed to ensure that each resident received assistance, if required, to use personal aids.

In an interview, the complainant indicated that resident #005 had a specified impairment and required an identified personal aid. The complainant stated they had informed the staff since the resident's admission to the home on an identified date in 2018, that resident #005 required assistance to use the identified personal aid when up in their wheelchair and during meals. During the interview, the complainant indicated during their visits with the resident, the resident was not using the identified personal aid.

A review of resident #005's written plan of care indicated that the resident had the specified impairment and the staff were directed to ensure that the resident used the identified personal aid at all times, since the resident's admission to the home.

During observations conducted on an identified date, the resident was not using their identified personal aid during an identified meal and, thirty five minutes later while sitting in their wheelchair in a common resident home area.

In an interview, PSW #112, indicated that resident #005 was to use the identified personal aid at all times. The PSW stated that they had forgotten to provide assistance to the resident to use the identified personal aid on the above mentioned date.

In an interview, the DNC indicated that resident #005 had the specified impairment and it was important for the resident to use the identified personal aid. The staff failed to ensure that the resident #005 received assistance to use the identified personal aid.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 1) The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

The home received a complaint from resident #005's SDM on an identified date in 2019, regarding the resident's medication management.

In an interview, resident #005's SDM, indicated that they did not receive a response from the home after making the complaint to the home's AGM on the identified date.

In interviews, the DNC and AGM, indicated it is the home's process for complainants to receive a response from the home within 10 days. The DNC indicated that the AGM had provided a response to the SDM on an identified date in 2019, after it was brought to their attention by the inspector. The DNC and AGM acknowledged that the SDM did not receive a response from the home within 10 days of the complaint.

Issued on this 15th day of May, 2019

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

Original report signed by the inspector.