Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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
Oct 2, 2019	2019_641665_0016	008277-19, 010484-19, 010485-19, 010577-19, 010639-19, 012196-19, 013063-19, 013221-19, 014071-19, 015613-19	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

JOY IERACI (665), NITAL SHETH (500)

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): August 23, 26-30, September 3-6, 9 and 10, 2019. Off site September 11, 2019.

The following intake logs were inspected:
- Follow Up Log #010484-19 related to plan of care
- Follow UP Log # 010485-19 related to abuse
- Critical Incident System (CIS) Logs #013063-19/CIS #2957-000035-19, #014071-19/CIS #2957-000039-19, #015613-19/CIS #2957-000043-19, #010577-19/CIS #2957-000029-19, #012196-19/CIS #2957-000032-19 and #013221-19/CIS #2957-000036-19, related to falls prevention and management
- CIS Log #008277-19/CIS #2957-000023-19 related to responsive behaviours
- CIS Log #010639-19/CIS #2957-000030-19 related to abuse

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), Kinesiologist, Administrative Assistant (AA), Personal Support Workers (PSWs), Housekeeping Aide (HA), substitute decision makers (SDM) and residents.

During the course of the inspection, the inspectors observed staff and resident interactions, reviewed clinical health records, training records, relevant home policies and procedures and other pertinent documents.

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

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

2 WN(s)
1 VPC(s)
0 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. 19. (1)	CO #002	2019_641665_0008	665
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2019_641665_0008	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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The home has failed to ensure that the care set out in the plan of care was based on an assessment of resident #004's needs and preferences.

The home received a compliance order (CO) #002 on May 13, 2019, under inspection #2019_641665_0008 involving resident #004 with a compliance due date of August 15, 2019.

In an interview, resident #004 indicated they had an identified preference as part of their bedtime routine. The resident stated that they like to be tidy and some PSWs did not include the identified preference at bedtime.

A review of the resident's current plan of care under sleep patterns did not have documentation on resident #004's identified preference as part of their bedtime routine.

In interviews, PSWs #115, #121 and #123 indicated that resident #004 was very particular with their bedtime routine and would exhibit two identified behaviours when care was not provided according to the resident's preferences and routine. The PSWs stated the identified preference had been the resident's preference for a long time. PSW #115 stated they have provided care to the resident for over two years and the bedtime routine had been the same.

In an interview, the DNC, indicated that they were not aware of resident #004's identified preference at bedtime. The DNC stated that the preference should have been in the plan of care so that PSWs were aware of the resident's needs and preferences. The DNC acknowledged that the home failed to ensure resident #004's plan of care was revised based on their preference at bedtime.

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #007 as specified in the plan.

A review of the Critical Incident System (CIS) report #2957-000043-19 indicated that resident #007 had an unwitnessed fall on an identified date and shift in 2019. The resident sustained identified injuries and was transferred to the hospital.

A review of the resident's written care plan indicated that the resident was at risk for falls.

A review of the resident's progress notes indicated that the resident had an unwitnessed fall one day prior the critical incident (CI) noted above. Interventions were implemented as a result of the post fall assessment, included three identified interventions to reduce the risk of another fall or injury.

A review of the resident's progress notes indicated that the resident had another unwitnessed fall 12 days after the CI. One of the three identified interventions mentioned above was not implemented at the time of the fall as RPN #117 indicated that the identified intervention was not in place during the resident's fall. RPN #117 stated the fall could have been prevented if the identified intervention was implemented.

In interviews, PSW #118, RPN #117 and NCC #107 indicated that the staff were expected to be aware of the resident's plan of care and implement it. Resident #007's identified interventions should have been implemented to prevent their falls.

This non-compliance is issued as a result of staff failure to implement resident #007's falls prevention care plan.

3. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

The home submitted a CIS report to the Ministry of Long Term Care (MLTC) related to a fall resident #001 had on an identified date in 2019, where the resident sustained a specified injury.

A review of resident #001's current falls management plan of care indicated for the resident to use an identified intervention.

During observations conducted on an identified date and time, the resident was observed sitting in a mobility device, attempting to get up. In conversation with PSW #124, they stated that resident #001 was no longer using the identified intervention.

In an interview, PSW #125 indicated that they were the assigned PSW for resident #001 when the inspector conducted the observations, and that the resident was at risk of falls. The PSW stated that they did not implement resident #001's identified intervention, as specified in the plan of care.

In an interview, ADNC/Falls Lead #101 indicated it was expected for staff to follow the plan of care. The ADNC stated that resident #001 was at high risk for falls and was a frequent faller. In the interview, the ADNC acknowledged that PSW #125 should have followed resident #001's plan of care related to the identified intervention.

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 care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident and the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

The licensee has failed to ensure that direct care staff were provided training in falls prevention and management.

A record review of the home's falls prevention and management training records for 2018, indicated that six percent of direct care staff did not receive training in the home's falls prevention and management program. A further review of the training records documented that PSW #126, who was present at the time of resident #001's fall on an identified date in 2019, did not receive the training.

In an interview, the DNC stated that all direct care staff are provided training on falls prevention and management annually through the home's online education module, Marketplace. The DNC indicated that PSW #126 was not scheduled for the training in Marketplace for 2018, and have recently scheduled the training for 2019.

The licensee has failed to ensure that all direct care staff received training in falls prevention and management.

Issued on this 4th day of October, 2019

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

Original report signed by the inspector.