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

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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_0017	009981-19	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): August 30, September 3-6, 10, 2019.

The complaint intake log #009981-19 related to skin and wound and infection prevention and control 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), Registered Nurses (RNs), Registered Practical Nurses (RPNs) and substitute decision makers (SDM).

During the course of the inspection, the inspector reviewed clinical health records, and relevant home policies and procedures and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others involved in the different aspects of care of resident #008 collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other; and (b) in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

The Ministry of Long Term Care (MLTC) received a complaint through the ACTIONLine on two identified dates in 2019, within the same month related to the home's management of resident #008's identified altered skin integrity.

In an interview, the complainant indicated that resident #008 had the identified altered skin integrity on their body and was treated for a specified diagnosis. The complainant stated that they had received conflicting information regarding the diagnosis of the resident's altered skin integrity from the home's management. The complainant further indicated that the home did not communicate to them that the treatments ordered by the physician was to treat the specified diagnosis.

A review of resident #008's weekly skin and wound observation tool in point click care (PCC) on an identified date in 2019, indicated that the resident had the identified altered skin integrity.

A review of the progress notes by the nurse practitioner (NP) on an identified date in 2019, indicated they assessed the resident's altered skin integrity and suspected two specific diagnosis and ordered a referral to a specified consultant and an identified treatment for the suspected diagnosis.

A further review of the progress notes indicated that RPN #127 obtained consent for the specified consultant and the identified treatment from the complainant on the following day. In an interview, RPN #127 stated that they had called the complainant to obtain consent for the NP's orders noted above. The RPN indicated that they had communicated to the complainant that the NP was referring the resident to a specified consultant to confirm what the altered skin integrity was and that the identified treatement was for the altered skin integrity. RPN #127 stated they did not communicate to the complainant the NP's assessment and that the NP suspected that the altered skin integrity to be the specified diagnosis.

In an interview, DNC indicated when the identified treatment was ordered by the NP, it was the home's process for the registered staff to obtain consent from the resident or the SDM and communicate the assessment of the NP. The DNC indicated it was their expectation for RPN #127 to have communicated the NP's assessment informing the SDM what the treatment was for and the NP suspected the altered skin integrity to be a specified diagnosis to ensure the information was consistent with the NP's assessment.

A further review of the clinical records indicated that the consultant assessed the resident's altered skin integrity nine days after the NP ordered the consultant referral. The assessment stated "nil evidence of the specified diagnosis at present and nil treatment necessary at present".

A review of the progress notes, indicated that four days after the consultant's assessment, RN #114, documented they contacted the complainant to obtain consent for another identified treatment for the specified diagnosis for the resident.

In an interview, RN #114 confirmed they had contacted the complainant four days after the consultant's assessment, to obtain consent for another treatment. The RN indicated they informed the complainant that all residents in an identified resident home area were being treated with the other identified treatment as a prohylaxis for the specified diagnosis. RN #114 stated that they told the complainant that resident #008 was suspected to have the specified diagnosis. The information communicated to the complainant was not consistent with the consultant's assessment four days prior.

In an interview, RN #127 who was the previous DNC indicated they had a conversation with the complainant and provided them the outcome of the consultant's assessment.

The RN indicated they informed the complainant the resident had the specified diagnosis. RN #127 acknowledged that the information provided to the complainant was not consistent with the assessment of the consultant.

In an interview, DNC indicated they had received a complaint from the complainant on an identified date in 2019, regarding the care the resident received to manage the altered skin integrity. The DNC stated they had informed the complainant that based on the consultant's assessment, the resident did not have the specified diagnosis. However, the complainant was upset with the home as they were already informed by RNs #114 and #127 that the resident had the specified diagnosis. The DNC indicated the resident received treatment for the specified diagnosis but the diagnosis was not confirmed, but suspected. The DNC acknowledged the complainant received conflicting information regarding the diagnosis of the altered skin integrity which were not consistent with the assessment of the consultant. The DNC indicated that RNs #114 and #127 did not collaborate in the implementation of the resident's plan of care so that the care of resident #008's altered skin integrity was integrated and consistent with each other.

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.