Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Feb 7, 2020	2019_641665_0025	022017-19	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): December 11, 13, 16, 17, 2019, and January 2 and 3, 2020.

The following intake log #022017-19 related to hospitalization and change in condition was inspected.

During the course of the inspection, the inspector(s) spoke with the Assistant General Manager (AGM), Interim Director of Nursing Care (IDNC), Neighbourhood Coordinator (NC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), and family members.

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

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002's substitute decision-maker, was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The Ministry of Long Term Care (MLTC) received a complaint through the ACTIONLine on an identified date in 2019, regarding resident #002's transfer to hospital.

In an interview, the complainant indicated they were the substitute decision maker (SDM) for resident #002 and was not notified by the home that the resident was transferred to hospital on the identified date in 2019. The complainant stated that they were notified by one of their family members that the resident was in hospital.

A review of resident #002's clinical records in point click care (PCC) documented there were an identified number of SDMs for the resident and they were all identified as emergency contact number one.

In interviews, RN #105, NC #102 and IDNC #100 indicated that there were an identified number of SDMs for resident #002 and there was no designated main contact for personal care decisions. The staff indicated that all SDMs had equal authority to make personal care decisions for resident #002.

A review of resident #002's advanced care planning assessment on an identified date in 2019, completed by IDNC #100, documented it was completed with a SDM. The assessment did not indicate the name/s of the SDM that provided consent.

A further review of the resident's progress notes in PCC indicated that a care conference was held six weeks after the advanced care planning assessment noted above was completed, and the resident's care levels were reviewed. Half of the SDMs were in attendance at the care conference and provided their consent for resident #002's advanced care planning decision.

In an interview, IDNC #100 indicated that when the advanced care planning assessment was completed, the SDM had to be consulted and provide consent if the resident was incapable to make the decision. For resident #002, since there were an identified number of SDMs who had equal authority to make personal care decisions which included advanced care planning, all of the SDMs needed to be consulted and provide consent. IDNC #100 indicated when they completed the advanced care planning assessment on the identified date, they only received consent from one of the SDMs.

The IDNC reviewed the progress notes from resident #002's care conference and stated that all of the SDMs did not participate in the resident's advanced care planning. The IDNC acknowledged that the home did not ensure that all of resident #002's SDMs were given an opportunity to participate fully in the development and implementation of the resident’s plan of care.

The information was reviewed with AGM #106 and they confirmed that resident #002 had an identified number of SDMs for personal care with equal authority to make personal care decisions. The AGM acknowledged that all of the SDMs were not given an opportunity to participate fully in the development and implementation of resident #002's plan of care. [s. 6. (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 resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

Issued on this 10th day of February, 2020

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

Original report signed by the inspector.