Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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
May 25, 2020	2020_751649_0005	023672-19, 024124-19, 000184-20, 001343-20, 001627-20, 001830-20, 001930-20	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

JULIEANN HING (649), ADAM DICKEY (643)

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): March 4, 5, 6, 10, 11, and 12, 2020.

The following intakes were completed in this Critical Incident System (CIS) Inspection:
Log #023672-19/ CIS #2957-000061-19 related to transferring and positioning technique.
Log #024124-19/ CIS #2957-000065-19 related to plan of care.
Logs #000184-20/ CIS #2957-000002-20, #001343-20/ CIS #2957-000005-20, #001627-20/ CIS #2957-000009-20, and #001930-20/ CIS #2957-000013-20 related to falls prevention and management.
Log # 001830-20/ CIS #2957-000012-20 related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the director of nursing care (DNC), registered nurse (RN), registered dietitian (RD), registered practical nurses (RPNs), kinesiologist, personal support services (PSWs), and residents.

During the course of the inspection the inspectors reviewed residents' health records, staffing schedules, investigation notes, conducted observations related to the home's care processes, and reviewed relevant policies and procedures.

During the course of this inspection non-compliance was identified under s. 6. (7) of the Long-Term Care Homes Act, 2007 (LTCHA, 2007).

The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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)

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was in compliance with and was implemented in accordance with all applicable requirements under the Act.

In accordance with O. Reg. 79/10, s.68 (2) (b), the licensee shall ensure the identification of any risk related to nutrition care and dietary services and hydration.

A critical incident system (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) related to an incident of staff to resident neglect. According to this report when resident #001 experienced a change in their health condition staff neglected to respond to the resident. Resident #001 did not experience a negative outcome.

A review of the home’s policy titled Nutritional Care, under the home's Nutrition and Hydration, policy #07-24 reviewed on November 27, 2019, indicated below as follows:
-At the end of each day (24-hour period) the clinical software calculates all food and fluid consumed by the resident. The night RPN/RN will review the Look Back Report. Any resident that has a fluid intake less than their fluid requirements will be reported to the on-coming RPN/RN so that support strategies/ interventions can be initiated.
-The RPN/RN will assess for signs and symptoms of dehydration. If a resident exhibits one or more signs and symptoms of dehydration a Dietitian referral is required with particular attention paid to the answering of the Hydration section in the referral.
-If a resident's fluid intake is less than 1000 mls for three consecutive days the resident will be referred to the registered dietitian.

A review of resident #001's assessments and progress notes did not indicate that a referral was sent to the RD when resident #001's fluid intake was less than 1000 ml for three consecutive days.

Record review and interview with RD #106 indicated resident #001's fluid intake in milliliters (mls) during an identified period was less than the required daily amount.

In an interview with RD #106, they acknowledged that they had not received a referral for resident #001 when their fluid intake was less than 1000 ml over three consecutive days during the above mentioned period, therefore confirming that the home's policy had not been followed.

In separate interviews with RN #105 and DNC #107, they both acknowledged that the home's nutrition and hydration policy had not been followed when resident #001's fluid intake over three consecutive days was less than 1000 ml. [s. 8. (1) (a),s. 8. (1) (b)]

2. In accordance with Regulation (O. Reg. 79/10, s. 48 (1). 1) the licensee was required to ensure that an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury was implemented in the home.

A written description of the program was required that included its goals and objectives and relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Review of the home's written program description titled "Fall Prevention and Management Program (LTC)" policy #06-02, reviewed May 14, 2019, showed head injury routine (HIR) was to be completed for unwitnessed falls and when a possible head injury is noted. Review of the home's policy titled "Head Injury Routine" policy #04-37, reviewed January 21, 2020, showed HIR is to be initiated for any known or possible head injuries.

CIS report was submitted to the Director related to an incident which resulted in resident #012 being transferred to hospital which resulted in a significant change in the resident's condition. Review of the CIS report showed that resident #012 was found coming out of the bed with an identified body area up against the bedside table, by a PSW staff member. The CIS report noted an area of altered skin integrity was identified for resident #012.

Review of resident #012's progress notes showed that RPN #103 was informed by a PSW staff member that resident #012 had been found with an identified body area up against the bedside table and body moved to one side of the bed; it appeared to the staff that the resident was attempting to get out of bed. Review of a weekly skin observation tool completed by RPN #103 for resident #012 showed an area of altered skin integrity on an identified body area. No documentation of HIR monitoring for resident #012 was identified related to the incident.

In an interview, RPN #103 indicated that they had received notification from PSW #112 that they needed to come and check on resident #012. The RPN indicated that the PSW told them the resident was found twisted to one side of the bed with an identified body area up against the bedside table. RPN #103 indicated that when they attended resident #012's room they noted that the resident was in the middle of the bed, and assessed them for injury, noting altered skin integrity on an identified area of the resident's body. RPN #103 indicated that due to the altered skin integrity found on the resident's body that a possible head injury should have been considered. The RPN indicated that as the resident was not reported to have fallen, they did not consider initiating HIR to monitor the resident's potential injury.

In an interview, RN #105 indicated that HIR would be initiated by the team lead or RPN on each unit when a resident had an unwitnessed fall, a fall with suspected head injury or when a resident had a possible head injury that was not related to a fall incident. The RN indicated that they had spoken to RPN #103 regarding the incident involving resident #012 and advised the RPN that as there was possible head injury as evidenced by an area of altered skin integrity on the resident and HIR should be initiated.

In an interview the DNC indicated that it was the expectation of the team lead (RPN) on the unit to initiate HIR for a resident who sustained an unwitnessed fall or when evidence of a possible head injury was noted. The DNC indicated that the area of altered skin integrity on the resident indicated evidence of a possible head injury, and would expect the registered staff to carry out HIR monitoring of the resident. The DNC acknowledged that as resident #012 was found with an identified body area up against the bedside table and altered skin integrity was found upon assessment, that HIR should have been completed for the resident and had not been completed as per the home's policy. [s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act, to be implemented voluntarily.

WN #2: 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. (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 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.

Two CIS reports were submitted to the MLTC related to two falls resident #001 had that resulted in them being transferred to the hospital and diagnosed with injuries.

According to the first CIS report related to resident #001's fall indicated that they had tried to stand up and slid from the couch landing on their back. A few days later the resident expressed pain to an identified body area despite pain medications and was transferred to hospital, where they were diagnosed with an injury.

A second CIS report was submitted related to resident #001's fall on the same date. According to this report resident #001 was being accompanied by a PSW, stepped back and lost their balance, hitting an identified body area on the bathroom door and sustaining an injury. The resident was transferred to hospital and diagnosed with an injury.

Record review indicated that resident #001 had a history of falls and had sustained three

falls with no injury prior to the above two falls with injuries. According to the first fall incident note resident #001 was observed wearing inappropriate footwear which may have contributed to them falling. As a result, the home implemented as a fall prevention intervention for resident #001 to wear shoes and discouraged the use of inappropriate footwear, which is part of the resident's plan of care. This intervention for the resident to wear shoes was never implemented by the home, therefore not following resident #001's plan of care.

Further record review indicated that resident #001 sustained a second fall and was observed wearing inappropriate footwear. According to the fall incident report the resident did not sustain an injury. The fall prevention intervention to have resident #001 wear shoes was not implemented, therefore not following the resident's plan of care.

Resident #001 sustained a third fall while wearing inappropriate footwear. The resident was transferred to hospital and diagnosed with an injury. The fall prevention intervention for resident #001 to wear shoes was not implemented, therefore their plan of care had not been followed.

A review of resident #001’s plan of care did not indicate any documentation that the fall prevention intervention for the resident to wear shoes had been implemented, therefore their plan of care had not been followed.

In an interview with RPN #101, they acknowledged that the fall prevention intervention for resident #001 to wear shoes had not been implemented after they fell as they were unable to find any documentation of the resident's response to this intervention. Therefore, they acknowledged that since the intervention for resident #001 to wear shoes had not been implemented, their plan of care had not been followed.

In an interview with DNC #107, they acknowledged that resident #001’s plan of care was not followed since the intervention for resident #001 to wear shoes had not been implemented.

Review of the home's Compliance History revealed a history of non-compliance related to the LTCHA, 2007, s. 6. (7). An order was issued under s. 6. (7) during inspection report # 2019_641665_0024 dated March 3, 2020, with a compliance due date of July 30, 2020. A written notice (WN) has been issued under s. 6. (7) with additional evidence for the existing order not past-due. [s. 6. (7)]

Issued on this 4th day of June, 2020

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

Original report signed by the inspector.