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 12, 2021	2021_751649_0008	016802-20, 016877-20, 017212-20, 017908-20, 018747-20, 022188-20, 022550-20, 024417-20, 003055-21	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)

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): April 20, 21, 22, and 23, 2021.

The following Critical Incident System (CIS) intakes were completed during this CIS inspection:
Logs #017212-20, CIS #2957-000029-20, #017908-20, CIS #2957-000030-20, #003055-21, CIS #2957-000004-21- related to falls prevention and management.

The following Compliance Order (CO) follow-up intake was completed during this CIS inspection:
Log #022550-20 - related to restraint

The following CIS intakes were completed related to falls prevention and management during this inspection:
Logs #024417-20, CIS #2957-000038-20, #022188-20, CIS #2957-000034-20, #018747-20, CIS #2957-000032-20, #016877-20, CIS #2957-000027-20, and #016802-20, CIS #2957-000025-20 - related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing Care (DNC), Assistant Director of Care (ADOC), Physiotherapist (PT), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Sanitizer, and residents.

During the course of the inspection the inspector observed staff to resident interactions, conducted resident observations, reviewed residents' clinical records and staffing schedules.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Minimizing of Restraining

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)**

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. 29. (1)	CO #004	2020_751649_0017	649

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. (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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

The home submitted a Critical Incident System (CIS) report related to a resident's unwitnessed fall that resulted in an injury. The resident's care plan indicated to have an accessible device within reach. Observation conducted by the inspector, PSW, and RPN, indicated that the resident's accessible device was not within their reach. The PSW told the inspector that the resident did not want the accessible device attached to their sheets. The RPN acknowledged being aware of this but could not recall since when. A PSW told the inspector that they had never seen the resident use the accessible device. They acknowledged being aware that the resident did not want the device attached to their sheets, and clarified that the resident did not want the device attached to their pillow to prevent them from moving while in bed. They were given instructions from the resident not to attach the accessible device to their pillow, and had been leaving the device on the bed beside the resident within their reach. The RPN was not aware of the resident's preferences related to the accessible device and was aware of it being beside the resident on their bed. They further stated that they had not seen the resident used the accessible device recently, and confirmed that the resident's care plan was not being followed. This was brought to the DNC's attention and they acknowledged that the accessible device should have been within the resident's reach.

Sources: resident's health records, home's investigation notes, interviews with PSW, DNC, and other staff. [s. 6. (7)]

2. The licensee has failed to ensure that two residents were reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan had not been effective and when the residents' care needs changed.

(a). The home submitted a CIS report related to a resident's unwitnessed fall that resulted in an injury. The resident's care plan indicated the use of a specific device when up in their mobility device. Observation conducted by the inspector and two PSWs, did not indicate the use of the specific device when they were observed up in the mobility device. The PSW told the inspector that the resident had not been using the specific device in their mobility device for several weeks, as it was not performing the way it should and was removed. The DNC and RPN both confirmed that the resident's care plan should have been updated and revised when this intervention was no longer effective.

Sources: resident's health records, home's investigation notes, interviews with PSW, RPN, DNC, and other staff.

(b). The home submitted a CIS report related to a resident's unwitnessed fall that resulted in an injury. The resident's care plan indicated that they should use a specified device. Two entries made in Point Click Care (PCC), indicated the resident's refusal of the specified device. Review of PSWs documentation in Point of Care (POC) indicated almost daily documentation of the resident's refusal of the specified device. The inspector conducted an observation and was told by the PSW that the resident had refused the specified device. Several staff confirmed that the resident was not compliant with the specified device. The DNC and RPN both acknowledged that the resident's care plan should have been revised and updated to reflect their refusal of the specified device.

Sources: resident's health records, home's investigation notes, interviews with RPN, DNC, and other staff. [s. 6. (10)]

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 ensure that the care set out in the plan of care is provided to the resident as specified in the plan, that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan has not been effective, and when, the resident's care needs change, to be implemented voluntarily.

Issued on this 13th day of May, 2021

[redacted]

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

Original report signed by the inspector.