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
Mar 4, 2022	2022_840726_0002	018134-20,006327-21, 011782-21,012471-21, 013102-21,013477-21, 013824-21,016544-21, 017866-21,017894-21, 018333-21,018337-21, 018596-21	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

REBECCA LEUNG (726), APRIL CHAN (704759), RODOLFO RAMON (704757)

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): January 27-28, 31, February 1-3, 7-11, 14, 2022, and off-site on February 15-17, 2022.

The following intakes were completed in this Critical Incident System (CIS) inspection:
Log #012471-21 and Log #013477-21 were related to prevention of abuse; Log #013102-21 and Log #017894-21 were related to unknown cause of fracture; Log #018134-20, Log #006327-21, Log #013824-21, Log #016544-21, Log #011782-21, Log #017866-21, Log #018337-21 and Log #018596-21 were related to falls prevention; Log #018333-21 was related to improper care and falls prevention.

During the course of the inspection, the inspector(s) spoke with the Interim Long-Term Care Administrator, Interim Director of Nursing Care (IDNC), Assistant Director of Nursing Care (ADNC), Neighbourhood Coordinators (NC), Resident Assessment Instrument (RAI) Co-ordinator, Physician, Physiotherapist (PT), Kinesiologist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspectors observed staff to resident interactions, reviewed residents' health records, home's investigation notes, annual program evaluation, policies and procedures; and completed a mandatory Infection Prevention and Control (IPAC) checklist.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

5 WN(s)
4 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure a safe and secure environment for its residents.

The inspector conducted observations related to IPAC practices in the home, and observed a number of visitors not wearing the required personal protective equipment (PPE) while they were visiting residents who were on additional precautions.

The home's related policy indicated that all staff and visitors are required to adhere to all additional precautions including the use of PPE. The IDNC acknowledged that all visitors are required to abide by all IPAC practices in the home and that the visitors were not wearing the required PPE. This placed residents at risk of contracting infectious agents.

Sources: Interviews with IDNC and other staff, observations, and the related home's policy. [s. 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 home is a safe and secure environment for its residents, 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. (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 a resident was reassessed, and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) related to a staff to resident physical abuse incident.

On the date of the incident, after the resident was assessed for their complaint related to the application of a medical device, the registered staff received a verbal order from the nurse practitioner (NP). The order was to hold the medical device until after a diagnostic report was available. The inspector reviewed the resident's clinical records and there was no evidence that the NP's verbal order was transcribed in the resident's plan of care.

The Interim Director of Nursing Care (IDNC) acknowledged that the above-mentioned verbal order from the NP should have been transcribed by the registered staff, and the resident's care plan should have been revised to reflect the change in the resident's care needs.

Sources: resident's clinical records, interviews with the IDNC and other staff. [s. 6. (10) (b)]

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.

A) A CIS report was submitted to the MLTC related to a fall incident in which a resident

sustained an injury post-fall. Prior to the fall incident, the resident was walking with an assistive device independently with supervision. The resident did not return to their baseline mobility function after the injury.

The resident had multiple fall incidents with no injury within a few months after admission. Assessments revealed that the resident had functional impairments and was at risk for fall. The staff members stated that prior to the above-mentioned fall incident, the resident would wander from room to room and forgot to walk with their assistive device sometimes.

The resident's care plan upon admission indicated that the resident was at risk for falls, and fall prevention strategies were put in place. No revision was made until the resident sustained an injury in the above-mentioned fall incident. The physiotherapist revised the care plan to include the use of a mobility device.

The registered staff acknowledged that they should have reviewed and revised the resident's plan of care after the recurrence of fall incidents.

Sources: CIS report, resident's clinical records, and staff interviews.

B) A CIS report was submitted to the MLTC related to a fall incident involving another resident. The resident sustained an injury post-fall in October 2021. Prior to this fall incident, the resident was walking using an assistive device with supervision. The resident did not return to their baseline mobility function after the injury.

The resident had a previous injury post-fall in April 2021 and multiple fall incidents with minor or no injury after.

Assessment revealed that the resident remained at risk for fall after receiving treatment for the injury sustained from the fall incident in October. The staff stated that the resident continued to try getting up from the mobility device on their own at times due to their functional impairment.

Prior to the fall incident in October 2021, the fall prevention strategies in the resident's care plan were last revised in April 2021.

The registered staff acknowledged that they should have reviewed and revised the

resident's plan of care after the recurrence of fall incidents.

Sources: CIS report, resident's clinical records, and staff interviews. [s. 6. (10) (c)]

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 is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary; or care set out in the plan has not been effective, to be implemented voluntarily.

WN #3: 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 the Continence Program policy was complied with, for a resident.

In accordance with O. Reg. 79/10, s. 48 (1), the licensee was required to develop and implement a continence care and bowel management program in the home to promote continence and to ensure that residents are clean, dry and comfortable.

Specifically, staff did not comply with the LTC home's Continence Program policy.

A resident had an unwitnessed fall in the washroom. According to a CIS report, a PSW left the washroom while the resident was sitting on the toilet. The PSW heard a loud sound, when they returned to the washroom, the resident was on the floor and had sustained an injury.

The LTC home's Continence Program policy indicated that residents with a specified functional impairment may never be left unattended on the toilet.

Clinical record review of the resident indicated that the resident had the specified functional impairment. The resident required 1-2 person extensive assistance for toileting.

The registered staff acknowledged that the resident required supervision during toileting and was left unattended. The PT confirmed that the resident should not have been left unattended on the toilet. The home's investigative notes concluded that the PSW left the resident unattended while they were on the toilet, which resulted in injury.

Sources: CIS report, staff interviews, LTC home's Continence Program Policy and investigative notes. [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 the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was protected from physical abuse by a staff member.

Under O. Reg. 79/10, s.2 (1), for the purpose of the definition, "physical abuse" means the use of physical force by anyone other than a resident that causes physical injury or pain.

A CIS report was submitted to the MLTC related to a staff to resident physical abuse incident. A resident reported that a staff member was rough during the application of a medical device, which caused them terrible pain since then. Initial assessment revealed a high pain level, and a reduced pain level in the subsequent assessment after analgesic was administered.

The resident was also assessed by a nurse practitioner and a diagnostic test was ordered. The medical device was on hold until the result was available. The resident’s family was informed, and emotional support was provided to the resident.

The resident had no further complaint of pain a few days after the incident. The diagnostic test report showed a specified diagnosis. The physician’s note indicated that

no further treatment was required related to resident's mobility status.

Resident's care plan indicated that the resident required two-person assistance for personal care.

The physiotherapist stated that the specified diagnosis was likely related to the above-mentioned incident.

The staff member involved denied being rough while they were providing care to the resident on the date of the incident, and admitted that they applied the medical device for the resident by themselves; without a second staff member present to assist with supporting the resident during the provision of care. The staff member acknowledged that they should have waited until their partner arrived and applied the medical device for the resident with two-person assistance.

The IDNC acknowledged that the incident had met the definition of physical abuse under the regulations.

Sources: CIS report, resident's clinical records, and staff interviews. [s. 19. (1)]

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 all residents are protected from abuse by anyone and are not neglected by the licensee or staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that where an incident occurred that caused an injury to a resident for which the resident was taken to a hospital, after determining that the injury had resulted in a significant change in the resident’s health condition, the Director was informed of the incident no later than three business days after the occurrence of the incident.

A resident had a fall incident on a specified date and no injury was noted upon assessment by registered staff. The next day, the resident complained of pain and change in their mobility function. The resident was then transferred to the hospital for assessment.

A progress note entered two days later indicated that the resident was admitted to hospital with a specified diagnosis and was going to receive treatment on that day.

A CIS report related to the above-mentioned fall incident was submitted to the MLTC five business days after the occurrence of the fall incident.

The IDNC acknowledged that they should have submitted the CIS report related to the above-mentioned fall incident no later than three business days after the occurrence of the incident.

Sources: CIS Report, staff interview, resident’s clinical records. [s. 107. (3.1) (b)]

Issued on this 8th day of March, 2022

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

Original report signed by the inspector.