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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
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Original Public Report

Report Issue Date June 3, 2022
Inspection Number #2022_1440_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiate ☐ Post-occupancy
☐ Other _____

Licensee
Schlegel Villages Inc
325 Max Becker Drive, Suite. 201, Kitchener, ON, N2E4H5

Long-Term Care Home and City
The Village of Humber Heights
2245 Lawrence Ave West
Etobicoke, Ontario

Lead Inspector
Noreen Frederick (ID #704758)

Additional Inspector(s)
Joanne Zahur (ID #589)

Inspector Digital Signature
Noreen Frederick
2022.06.13 10:44:24 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 10, 11, 12, 13, 16, and 17, 2022.

The following Critical Incident System (CIS) intakes were completed during this inspection:
Log #005184-22, CIS #2957-000010-22 related to Falls Prevention and Management ,
Log #006731-22, CIS #2957-000011-22) related to Falls Prevention and Management, and
Log #002194-22, CIS # 2957-000003-22) related to a Medication Administration.

The following Complaint intake was completed during this inspection:

Log #002070-22 related to Plan of Care, Skin and Wound Prevention and Management, Transferring/Positioning techniques, Nutrition, and Neglect.

The following **Inspection Protocols** were used during this inspection:

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Medication Management

- Skin and Wound Prevention and Management
- Resident Care and Support Services

INSPECTION RESULTS

During this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable.

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: s. 102 (2) (a)

The licensee has failed to ensure any surveillance protocols issued by the Director for a particular communicable disease or disease of public health significance are complied with.

Observations of the home's Infection Prevention and Control (IPAC) practices identified screener #104 did not follow the manufacturer's instructions of the rapid antigen test (RAT) device. The instructions on the RAT kit indicated that the swab with the collected specimen to stand in the extraction tube solution for two minutes prior to dispensing into the kit's testing device. The home failed to keep the swab standing in the extraction tube for 2 minutes as per manufacturer's direction.

Interim Director of Resident Care (IDRC) #102 acknowledged that the manufacturer's instructions were not being followed to ensure accuracy of the test results.

There was actual risk of harm to residents, staff and visitors related to not following the RAT device's instructions as they pertain to the accuracy of the test results and consequently potential spread of infectious disease.

Sources**:** IPAC observation, review of BTNX Rapid Response device's instructions, interviews with IPAC Lead #102, screener #104 and other staff.

[589]

WRITTEN NOTIFICATION ADMINISTRATION OF DRUGS

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 131 (1)

The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1)

On an identified day, resident #003 was administered multiple oral medications prescribed for resident #004.

An interview with Registered Practical Nurse (RPN) #107 indicated they administered their treatment to resident #003, leaving oral medication in the medication bin. Upon returning to the medication cart, RPN #107 took out resident #004's prescribed medications in error and administered to resident #003.

IDRC acknowledged that a medication error had occurred, involving RPN #107 and resident #003.

There was a moderate risk to the resident at the time of the incident due to receiving medications that weren't prescribed to them

Sources: medication incident report, resident #003's progress note documentation, CIS #2957-000003-22, RPN #106 and #107 written statements, interviews with registered staff #106, #107, #105 and others.

[589]

WRITTEN NOTIFICATION SKIN AND WOUND CARE

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 50 (2) (b) (iii)

The licensee has failed to ensure that when resident #001 exhibited altered skin integrity on two identified dates, a registered dietitian referral was sent for assessment.

Resident #001's progress notes and Skin & Wound Evaluation Notes revealed that the resident developed an alteration to their skin integrity on an identified date which was healed and then re-opened again. Both times, a registered dietician referral was not sent for assessment.

According to the home's Skin and Wound Care Program policy Nursing (RN and RPN) were to refer to the dietitian using the dietitian referral form-altered skin integrity including skin breakdown, pressure injuries, skin tear and wounds.

RPN #113, RPN # 114, and Wound Care Co-Lead #116 stated that a referral to the registered dietician was not sent on both identified dates.

IDRC #102 stated that staff were expected to send a dietitian referral both times when the resident experienced skin alterations.

By not sending registered dietician referrals, there was a risk of delay in the treatment plan.

Sources: resident #001's record reviews, home's Skin and Wound Care Program policy (Tab 04-78), interviews with RPN #113, RPN #114, Wound Care Co-lead #116, and IDRC #102.

[704758]

WRITTEN NOTIFICATION PLAN OF CARE

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 6 (7)

The licensee has failed to ensure the care set out in the plan of care was provided to the resident #001 as specified in the plan.

Resident #001's care plan indicated the staff were to apply a therapeutic device to resident #001 on each shift. Personal Support Worker (PSW) #115, PSW #118 and PSW #119 stated that the resident did not have such device and it was not applied to the resident on their shifts as indicated in the resident's care plan.

IDRC #102 stated that staff were expected to apply the therapeutic device as specified in the care plan.

Since the therapeutic device was not applied to the resident as specified in their plan of care, it was probable that it contributed to the resident developing a pressure injury on an identified date.

Sources: resident #001's care plan, interviews with PSW #115, PSW #118 PSW #119 and IDRC #102.

[704758]

WRITTEN NOTIFICATION PLAN OF CARE

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 6 (10) (c)

The licensee has failed to ensure the resident #001 was reassessed, and the plan of care reviewed and revised when, care set out in the plan has not been effective.

Resident #001's care plan indicated the staff to turn and reposition the resident every two hours. Wound care Co-Lead #116 and IDRC #102 stated the pillows used in repositioning of the resident were ineffective, hence the resident was not being repositioned. Additionally, they stated that no new interventions were trialled or implemented.

By not reassessing and reviewing and revising the care plan with new interventions for turning and repositioning, It is probable that it contributed to the resident developing two pressure injuries on two identified days.

Sources: resident #001's care plan, interviews with Wound Care Co-Lead # 116 and IDRC #102.

[704758]

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REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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Toronto ON M2M 4K5
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TorontoSAO.moh@ontario.ca

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West,9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.