Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
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Toronto, ON, M2M 4K5
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Original Public Report

Report Issue Date: November 29, 2022	
Inspection Number: 2022-1440-0003	
Inspection Type: Critical Incident System	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: The Village of Humber Heights, Etobicoke	
Lead Inspector Matthew Chiu (565)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 27, 2022
October 28, 2022
October 31, 2022
November 1, 2022
November 2, 2022
November 3, 2022

The following intake(s) were inspected:

- Intake: #00011844 related to an incident that caused significant injury to a resident

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

Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #01 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (1) (c).

The licensee has failed to ensure that a resident's written plan of care set out clear directions for monitoring the resident.

Rationale and Summary:

During a shift, an incident occurred and resulted in significant injury to a resident. Record review and staff interviews indicated the resident had demonstrated responsive behaviours. Their plan of care included a monitoring to the resident, however, the resident required a condition that was related to the monitoring.

In approximately three months prior to the incident, the resident was identified with a specified behaviour. In the following month, the resident was assessed by the external Behavioural Supports Ontario (BSO) team in relation to their behaviour and was identified with a risk that related to the above-mentioned incident. Subsequently, the resident was transferred to the hospital, and upon their return, the monitoring to the resident was continued.

The resident's plan of care, during that time, stated that the resident has been on the monitoring. However, staff interviews and record review confirmed that the resident's plan of care did not set out clear directions for the monitoring which required specific directions to their responsive behaviours and condition.

Sources: Resident's progress notes, care plan; interviews with the Registered Practical Nurse (RPN), Neigbourhood Coordinator (NC), Director of Nursing Care (DNC), and other staff. [565]

COMPLIANCE ORDER CO #01 WINDOWS

NC #02 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 19

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee shall:

A) Ensure that an evaluation of the window height limiters (similar or same) used in the specified resident's room is completed.

To ensure the efficacy of the evaluation, document the professional profile for the chosen evaluator(s) describing the evaluators qualifications to undertake the evaluation.

A record of the evaluation must be maintained and include the date, name, and designation of the evaluator, the window location(s), evaluation outcomes, and remedial actions taken if any.

B) Complete an audit of every window in the home equipped height limiters like the height limiters used in the same resident room.

The audit must ensure that every window that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

A record of the audit must be maintained and include the date, name and designation of the auditor, the window location(s), audit outcomes, and remedial actions taken if any.

Grounds

Non-compliance with: O. Reg 246/22, s. 19.

The licensee has failed to ensure that the window in one resident’s room that opened to the outdoors and was accessible to the resident had a screen and could not be opened more than 15 centimetres.

Rationale and Summary:

Record review and staff interviews indicated a resident had responsive behaviours. The resident’s plan of care included a monitoring to the resident.

The resident’s room had a window that was equipped with a screen and height limiters to prevent it from opening more than 15 centimetres. After the resident was identified with a specified behaviour, in the following month, the resident was further assessed by the external BSO team and resulted in an identified risk to their responsive behaviour.

A review of surveillance camera footage, incident report, and staff interviews indicated that during a shift, an incident occurred. It was found that the window in the resident room was opened more than 15 centimetres and it did not have a screen. The NC and DNC also confirmed that the window height

limiters were missing from the window; and therefore, it could be opened more than 15 centimetres. As a result of the incident, the resident sustained a significant injury.

Sources: Resident's incident report, progress notes, care plan; interviews with the NC, DNC, and other staff. [565]

This order must be complied with by February 14, 2023

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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) 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:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) 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:

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
e-mail: 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.