Ontario

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

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

Toronto District
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Original Public Report

Report Issue Date: March 6, 2023
Inspection Number: 2023-1440-0004
Inspection Type: Complaint Critical Incident System
Licensee: Schlegel Villages Inc.
Long Term Care Home and City: The Village of Humber Heights, Etobicoke

Lead Inspector	**Inspector Digital Signature**
JulieAnn Hing (649)	
Additional Inspector(s) Inspector #000705 was present during this inspection.	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
January 25, 26, 27, 31, February 1, 2, 3, 6, 7, and 8, 2023.

The following intake(s) were inspected:

- Intake: #00004940, Critical Incident (CI) #2957-000037-22 related to Falls prevention and management.
- Intake: #00018136 was a complaint intake related to neglect, dining and snack service, bathing, housekeeping, and medication administration.
- Intake: #00019329 was a complaint intake related to skin and wound care.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Housekeeping, Laundry, and Maintenance Services
Infection Prevention and Control
Recreational and Social Activities

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Obtaining and Keeping Drugs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (3)

The licensee has failed to ensure that no person administers a drug to a resident in the home unless that person was a physician, dentist, registered nurse or registered practical nurse.

Rationale and Summary:
The resident's medication administration indicated that the nurse gave a non-registered staff the resident's medication for them to administer to the resident. After the non-registered staff administered some of the medication to the resident, they left the medication cup with the remaining medication unattended at the resident's bedside.

The nurse's failure to administer the resident's medication put the resident at risk of not having their medication administered as ordered.

Sources: Observation of the resident's lunch medication administration on January 25, 2023, review of the resident's electronic-medication administration record (e-MAR), interviews with non-registered staff, and other relevant staff. [649]

WRITTEN NOTIFICATION: Obtaining and keeping drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that drugs were administered to the resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary:
(i) The resident was administered two medications crushed when instructions on their e-MAR directed staff not to crush.

The resident's admission orders signed by the physician indicated not to crush the two medications.

Staff interviews and record review indicated that the resident had always taken their medications crushed.

A Registered Practical Nurse (RPN) acknowledged that they had administered the resident's medications crushed. Another nurse acknowledged that the physician's orders were not followed.

Administering medications crushed to a resident when directions indicated not to crush put them at risk for decreased drug absorption.

Sources: Observation of the resident's medication administration on January 27, 2023, review of the resident's clinical records, interviews with nurses, and other relevant staff. [649]

Rationale and Summary:
(ii) The resident had physician's orders through the bowel protocol as follows:
On day 1: Give two Senokot by mouth and 30 cc Lactulose if no bowel movement;
On day 2: Give two Senokot by mouth and 30 cc Lactulose if no bowel movement;
On day 3: Give Dulcolax suppository rectally if no bowel movement; and
On day 4: Give fleet enema after lunch if no bowel movement.

The resident's Point of Care (POC) documentation for a period of three months indicated that the bowel protocol was not implemented as ordered on nine dates.

The physician's orders were not followed as only Lactulose was administered on two dates, and no medication was administered to the resident on six dates. The resident was administered a Dulcolax suppository when they should have received Lactulose and Senokot. There was no order of Senokot on the resident's e-MAR despite the physician's order of this medication since the resident's admission.

Failure of staff to follow the physician's bowel protocol orders put the resident at risk for constipation.

Sources: Review of the resident's clinical records, interview with ADNC, and other relevant staff. [649]

WRITTEN NOTIFICATION: Medication management system

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)

The licensee has failed to comply with the home's policies, developed for medication management system.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that the home's medication administration policy related to accurate administration of medication was complied with.

Rationale and Summary:
(i) Specifically, staff did not comply with the home's Resident care documentation policy that directed staff to sign the e-MAR only after the medication had been administered to the resident.

The resident's medication administration was observed.

An RPN told the inspector that they had not administered two of the resident's medications as they were unsure on how to administer one of the medications. The resident's Medication Admin Audit Report indicated that the nurse had signed for the administration of these two medications, even though they admitted that the medications had not been administered to the resident.

Signing for the administration of medications that were not administered put the resident at risk of not receiving their medications.

(ii) Staff did not comply with the home's Administration of medications policy that directed staff to remain with the resident until the medication had been swallowed.

The resident's medications were administered by a nurse while the resident was in the dining room. Sips of the two medications were provided to the resident by the nurse, and remaining medication left on the table in front of the resident, who was observed taking sips of the medication. While clearing the table, a PSW student discarded the remaining unfinished medication.

The RPN advised that they had mixed two medications together and administered it to the resident.

Failure to remain with the resident and ensure all medications were taken put the resident at risk of not receiving the correct medication dose.

Sources: Observation of the resident's medication administration on January 27, 2023, review of the resident's clinical records, home's Resident care documentation (policy #08-06, last reviewed on January 28, 2023), home's Administration of medications policy (policy 05-03, last reviewed on May 1, 2022), and interviews with RPN and other relevant staff. [649]

WRITTEN NOTIFICATION: Dining and snack service

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)

The licensee has failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide assistance to them.

Rationale and Summary:
Observation of dinner indicated that the resident's meal tray was left unattended at their bedside table for approximately 12 minutes before assistance was provided to them.

The resident's care plan indicated that they required assistance with eating.

Leaving the resident's meal tray unattended poses the risk of food being cold and resident refusing.

Sources: Observation of the resident's dinner meal tray on January 31, 2023, review of the resident's clinical records, interviews with Personal Support Worker (PSW), and other relevant staff. [649]

WRITTEN NOTIFICATION: Dining and snack service

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.

The licensee has failed to comply with the home's dining and snack service policies.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that the home's dining and snack policy related to the use of appropriate assistive devices was complied with during meal assistance.

Rationale and Summary:
Specifically, staff did not comply with the home's Dysphagia policy that directed staff to use a parfait spoon (long handled teaspoon) when providing total feeding assistance to a resident during meals.

Observation of the resident's lunch meal service indicated that they were provided total assistance with eating by staff using a large size spoon.

A Speech Language Pathologist (SLP) assessment directed staff to give teaspoon amounts to the resident.

The staff advised that the appropriate size spoon was not available.

Staff failure to use appropriate size spoon when providing total assistance to the resident put them at risk for receipt of more than a teaspoon amount.

Sources: Observation of the resident on January 25, 2023, review of the resident's clinical record, home's Dysphagia policy (policy 07-78, last reviewed on February 15, 2022), and staff interviews with Recreation Aide and other relevant staff. [649]

WRITTEN NOTIFICATION: Plan of care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)

The licensee has failed to ensure that two PSWs who provided direct care to the resident were kept aware of the contents of resident's plan of care and have convenient and immediate access to it.

Rationale and Summary:
(i) A PSW advised that they had access to the resident's plan of care. The inspector asked them to demonstrate how this was done, they were unable to show that they could access the resident's written care plan.

(ii) Another PSW was asked to show the inspector how they accessed information in the resident's written care plan. They logged onto the iPad but were unable to demonstrate that they could access the resident written care plan.

Failure to have immediate access to the resident's written care plan, and not kept aware of the contents of their plan of care put the resident at risk of not having care provided as per their plan of care.

Sources: Interview with two PSWs, and other relevant staff. [649]

WRITTEN NOTIFICATION: Plan of care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of care set out in the resident's plan of care was documented.

Rationale and Summary:
(i) Observation of lunch meal service indicated that the Recreation Aide had provided the resident total assistance during their lunch meal.

POC documentation of the resident's lunch intake indicated it had not been documented on the above-mentioned date. Further review indicated there was no documentation in POC of the care provided to the resident on the day shift on this date.

(ii) Review of POC documentation for the provision of the resident's shower on an identified dated indicated it was not documented.

A PSW acknowledged upon review of the resident's POC record that they had not documented the resident's lunch intake and had not documented the provision of the resident's shower.

Failure of staff to document the resident's meal intake, and provision of shower put the resident at risk of nutritional intake not being accurately recorded and provision of care not provided.

Sources: Observation of the resident's lunch meal on January 25, 2023, review of the resident's clinical record, interviews with Recreational Aide, PSW, and other relevant staff. [649]

WRITTEN NOTIFICATION: Plan of care

NC #008 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 there was a written plan of care for the resident that sets out clear directions to staff and others who provided direct care to the resident when administering medication.

Rationale and Summary:
(i) Observation of the resident's medication administration and interview with RPN confirmed that an identified medication was inappropriately administered.

Current order on the resident's e-MAR indicated to administer an identified medication a couple of times daily. Directions on the bottle indicated to mix in an identified amount of water and drink promptly. The directions on how to administer this medication was not included in the resident's e-MAR for staff to follow.

Based on the above medication administration and current order instructions for the medication provided unclear directions on how this medication should be administered to the resident.

An RPN advised that they had given the resident their medication inappropriately. They acknowledged being aware that the medication should have been diluted in water.

Another RPN acknowledged that the directions on the resident's e-MAR were unclear as it had not provided clear directions on how to prepare the medication for administration to the resident.

Failure to have clear medication directions in a resident's e-MAR put them at risk of having medications administered unsafely.

Sources: Observation of the resident's medication administration on January 27, 2023, review of the resident's clinical record, interviews with RPNs, and other relevant staff. [649]

Rationale and Summary:
(ii) An SLP assessment indicated to provide the resident with small mouthfuls to left side of their mouth. Another SLP assessment indicated to feed on left side and give teaspoon amounts.

Review of the resident's written care plan indicated SLP recommended slow feeding on the resident's left side.

Two RPNs both acknowledged that the above directions were unclear.

Sources: Review of the resident's clinical records, interviews with RPNs, and other relevant staff. [649]

WRITTEN NOTIFICATION: Plan of care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the resident's plan of care was provided to the resident as specified in the plan when administering medication, supplement, topical treatment, and when providing meal assistance.

Rationale and Summary:
(i) Observation indicated that the resident's medication was administered during their lunch meal.

The resident's plan of care directed staff to administer this medication before meals.

Failure to administer the medication at the correct time put the resident at risk of medication being less effective.

Sources: Observation of the resident's medication administration on January 25, 2022, review of the resident's clinical record, interview with Recreation Aide and other relevant staff. [649]

Rationale and Summary:
(ii) Observation of the resident's breakfast meal service indicated that they were provided a supplement, even though they had consumed more than an identified amount of their breakfast.

The resident's care plan directed staff to provide them with a supplement, if they consumed less than an identified amount of their meal. The resident's intake record documentation for this observation indicated that they had consumed in excess of an identified amount at their meal.

An RPN advised that they had administered the supplement to the resident, but they had not finished it.

Failure to administer supplements as ordered put the resident at risk of consuming more than they required.

Sources: Observation of the resident's breakfast and medication administration on January 27, 2023, review of the resident's clinical record, interviews with RPN, and other relevant staff. [649]

Rationale and Summary:
(iii) The resident's e-MAR indicated that registered staff were signing once daily for the application of an identified topical treatment for the resident.

A PSW advised that they had never applied the above-mentioned topical treatment to the resident. They denied the nurse ever asking them about the application of the treatment.

An RPN acknowledged that PSWs had been applying the identified topical treatment to the resident during care. They explained they knew this as they had inquired with the staff on its application, and had provided reminders to the staff before signing the resident's e-MAR. They later clarified that they had inquired with the PSW on the application of topical treatment to the resident but had not specifically about that type of topical treatment. They advised the inspector that the order will be discontinued.

Reviewed of the resident's e-MAR a few days later indicated that the nurse had signed for the application of the topical treatment on one day, even though the PSW had advised that they were not using this type of treatment.

Staff failed to follow the resident's plan of care of care for the application of an identified topical treatment.

Sources: Review of the resident's clinical record, interviews with PSW, RPN, and other relevant staff. [649]

Rationale and Summary:
(iv) Observation of lunch meal service indicated that they were provided total feeding assistance by the Recreation Aide and was not offered the opportunity to feed self. Therefore, the resident's care plan was not followed.

The resident's care plan indicated to encourage the resident to feed self. SLP assessments indicated to encourage resident to self-feed.

Failure to follow the resident's care plan put the resident at risk of not maintaining their independence.

Sources: Observation of the resident's lunch tray meal service on January 25, 2023, review of the resident's clinical records, interviews with Recreation Aide, and other relevant staff. [649]

WRITTEN NOTIFICATION: Skin and wound care

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iii)

The licensee has failed to ensure that the resident exhibiting altered skin integrity was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

Rationale and Summary:

No referral was sent to the Registered Dietitian (RD) for an identified site of altered skin integrity for the resident therefore, the resident was not assessed by the RD.

An RPN acknowledged that a referral was not sent to the RD. The RD acknowledged that a referral was not received for the resident's altered skin integrity.

Failure to send a referral to the RD put the resident at risk of not receiving an assessment.

Sources: Review of the resident's clinical records, interviews with RPN, RD, and other relevant staff. [649]

WRITTEN NOTIFICATION: Skin and wound care

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that the resident exhibiting altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary:
The resident was identified with an area of altered skin integrity. Their clinical records indicated that weekly skin and wound assessments were not completed on three dates.

An RPN acknowledged that the resident's weekly skin assessments were missed during the above-mentioned dates.

Failure to complete timely weekly skin and wound assessments put the resident at risk for delayed treatment and would healing.

Sources: Review of the resident's clinical records, interviews with RPN, and other relevant staff. [649]