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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Telephone: (866) 311-8002

Original Public Report

Report Issue Date: March 28, 2023

Inspection Number: 2023-1440-0005

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: Schlegel Villages Inc.

Long Term Care Home and City: The Village of Humber Heights, Etobicoke

Lead Inspector	**Inspector Digital Signature**
Ramesh Purushothaman (741150)	Ramesh Purushothaman Digitally signed by Ramesh Purushothaman Date: 2023.03.28 14:11:25 -04'00'

Additional Inspector(s)
Kim Lee (741072)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):
March 13-17, 20-22, 2023

The following intake(s) were inspected:
- Intake: #00015005 was related to a follow up.
- Intake: #00015090/ CI: 2957-000060-22 was related to improper care/potential physical abuse.
- Intake: #00018925/ CI: 2957-000003-23 was related to fall.
- Intake: #00021806 was a complaint related to potential verbal abuse.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #01 from Inspection #2022-1440-0003 related to O. Reg. 246/22, s. 19 inspected by Ramesh Purushothaman (741150)

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

Resident Care and Support Services
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 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 plan of care was provided to the resident as specified in the plan.

Rationale and Summary:
A resident sustained an injury when Personal Care Assistant (PCA) provided personal care. The care plan stated that staff were to use an intervention when the resident was resistive during their care.

PCA confirmed that when the resident was resistive to care, they did not use the intervention as indicated in the care plan. The resident was injured as a result of the interaction with the PCA.

The Director of Care (DOC) stated that the PCA did not use the intervention as indicated in the resident's written care plan and continued to provide care while the resident was resistive.

Failure of staff not following the care plan instructions puts the resident at risk for injury.

Sources: Resident's clinical records, Interview with PCA, and DOC.

[741150]

WRITTEN NOTIFICATION: RETRAINING

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)

The licensee has failed to ensure that a staff member who received training under subsection (2) received the retraining in the areas mentioned in that section at the intervals as provided for in the regulations.

FLTCA 2021 s. 82 (4) identified that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. O. Reg. 246/22 s. 260 (1) identified the retraining was to be completed at annual intervals.

Rationale and Summary:
A review of the LTCH's online training records for PCA, identified that the PCA had not completed any of the mandatory annual re-training for a period from 2020 to 2022, including education on Resident Bill of Rights, and home policy to zero tolerance of abuse and neglect of residents.

The DOC confirmed that the PCA did not complete any required courses for 2020, 2021 and 2022.

By not completing the annual education required for all direct care staff, it puts residents at further risk of injury because the staff may not be aware of how to perform their duties related to the topics covered in their education.

Sources: Review of staff annual online training records, interviews with PCA and the DOC.

[741150]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)

The licensee has failed to ensure that the Screener/Swabber participated in the implementation of the infection prevention and control (IPAC) program.

Rationale and Summary
On a specified date, the Screener/Swabber was observed wearing two surgical masks simultaneously.

The Screener/Swabber stated they chose to wear the double mask by their own volition because they wanted more protection and was not directed, nor trained, to wear two masks.

The IPAC Lead stated that the Screener/Swabber should not have been wearing two masks simultaneously and provided verbal education and direction to the staff member that same day to remove the second mask. The Screener/Swabber removed the second mask after IPAC Lead spoke with them. The next day, the Screener/Swabber was again observed wearing two surgical masks simultaneously.

The IPAC Lead stated that the LTCH's IPAC and personal protective equipment (PPE) training did not direct staff to wear two masks because that practice was ineffective, thereby putting residents at risk for infection. Further, the LTCH's IPAC PPE Policy did not direct staff to wear two masks simultaneously.

During the time of the observations, a home area of the LTCH was in outbreak for infectious disease. The Screener/Swabber did not participate in the implementation of the IPAC program by failing to wear PPE properly; this hampered the LTCH's infection control efforts.

Sources: Observations, interviews with staff, LTCH PPE policy and training materials.

[741072]