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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Original Public Report

Report Issue Date: June 7, 2023
Inspection Number: 2023-1440-0006
Inspection Type: Critical Incident System
Licensee: Schlegel Villages Inc.
Long Term Care Home and City: The Village of Humber Heights, Etobicoke

Lead Inspector	**Inspector Digital Signature**
Reji Sivamangalam (739633)	Reji K Sivamangalam Digitally signed by Reji K Sivamangalam Date: 2023.06.21 10:10:06 -04'00'

Additional Inspector(s)
Nrupal Patel (000755)
Rajwinder Sehgal (741673)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 16-19, 23-26, and 29, 2023

The following intake(s) were inspected:

- Intake: #00023016 [Critical Incident System (CIS) #2957-000008-23, related to fall prevention and management.
- Intake: #00085390 (CIS #2957-000011-23), related to alleged abuse
- Intake: #00085868 (CIS #2957-000012-23), related to improper care
- Intake: #00086643 (CIS #2957-000014-23), related to unexpected death of a resident

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

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

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary

A resident's plan of care indicated that they required one staff assistance for most of their Activities of Daily Living (ADL) tasks which could vary depending on the resident's personal expressions.

The staff member indicated that they have always used two-person assistance for ADL tasks due to the resident's personal expressions. They acknowledged that the resident's care plan did not provide clear directions for staff to provide direct care to the resident.

The Director of Care (DOC) acknowledged that the resident's plan of care instructions did not provide clear directions to staff for a specific level of assistance and should have been clearer for staff to follow.

The care plan was revised to provide clear directions to use two staff assistance when the resident exhibited personal expressions during the provision of care.

There was a risk that the resident may not have received the appropriate level of assistance due to unclear directions.

Sources: Resident's clinical records and progress notes, interviews with staff members

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Date Remedy Implemented: May 29, 2023

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The licensee has failed to ensure that staff collaborated with each other in the implementation of a resident's plan of care before a medical procedure.

Rationale and Summary

The resident was scheduled for a medical procedure at the hospital. The doctor's office's appointment instructions stated, "Nothing to drink or eat after midnight." The staff member noted the instructions in the appointment book that the resident's feed needed to be held after midnight. The resident received their morning medications with water and also drank some water before leaving for the appointment.

The staff member stated they did not receive instructions that the resident should not take anything by mouth. The registered staff stated that the instructions in the appointment book did not mention whether the resident could receive medications, and they did not clarify. The staff member confirmed that the appointment instructions were not communicated correctly to the staff, and staff were expected to clarify the instructions. The DOC acknowledged that the staff did not communicate with each other to clarify the instructions.

There was a risk to the resident when the staff did not collaborate with each other in clarifying the instructions for the resident's preparations before their medical procedure.

Sources: Resident's clinical records, interviews with staff members and DOC

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WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

(i) The licensee has failed to ensure that care set out in the care plan was provided to a resident as specified in the plan.

Rationale and Summary

A Critical Incident System (CIS) report was submitted to the Director regarding the alleged physical abuse of a resident.

The resident required two staff assistance for dressing. The resident was provided personal care by one staff member, which was inconsistent with the required level of assistance specified in their care plan.

The staff member confirmed that they had provided care to the resident by themselves.

The staff member was aware of the resident's care plan and acknowledged that the second staff was not present when they assisted the resident.

The DOC acknowledged that the resident required two-person assistance for dressing, and the resident's care plan was not followed as required. There was a risk of harm to the resident when the care plan was not followed.

Sources: CIS report, resident's clinical records and progress notes, interview with staff members.

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(ii) The licensee has failed to ensure that a resident received nutritional support per the dietitian's order.

Rationale and Summary:

A resident required nutritional support, and Registered Dietitian (RD) ordered a specified amount daily of formula to be provided. The resident did not receive the prescribed amount for several days in a specific period. The staff member verified that the resident did not receive the nutritional support per the order. The RD stated that the resident was required to receive the nutritional support according to their estimated requirements. The DOC confirmed that staff were expected to provide the nutritional support per the RD's order.

There was a risk of reduced nutritional intake when the resident did not receive the required amount of nutritional support as per the plan of care.

Sources: The resident's clinical records, interviews with staff members.

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WRITTEN NOTIFICATION: Required Programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee has failed to complete the head injury routine (HIR) assessment after a resident's unwitnessed fall.

In accordance with O. Reg. 246/22, s.11 (1) (b), the licensee was required to have a falls prevention and management program that provided strategies to monitor residents and must be complied with.

Specifically, staff did not comply with the home's HIR policy which was included in the licensee's Falls Prevention and Management Program.

Rationale and Summary

A resident had an unwitnessed fall.

According to the home's policy, HIR assessments were to be completed following the timeframes indicated in the electronic form.

Head Injury Routine assessment was initiated post-fall, but one of the required checks was not completed.

Registered staff indicated the expectation was to complete HIR at specified intervals.

The DOC stated that staff were expected to complete all checks as per the timeframes indicated on the head injury routine assessment electronic form. They verified that all checks were not complete after the resident's fall.

The DOC acknowledged that failure to complete the head injury assessment routine per the home's policy placed the resident at risk of not being properly assessed for post-fall injuries.

Sources: Review of home's "Falls Prevention and Management (LTC)" policy, resident's clinical records, Interview with registered staff and DOC.

WRITTEN NOTIFICATION: REQUIRED PROGRAMS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.

The licensee has failed to ensure that staff assessed a resident's pain when reported.

In accordance with O. Reg. 246/22 s 11 (1) (b), the licensee is required to ensure that there are policies developed for the pain management program and that they are complied with. Specifically, the staff did not comply with the home's Pain Management Policy as it required staff to complete an assessment when pain was reported to them by any staff or family member.

Rationale and Summary

A resident had a procedure at the hospital and returned home. A staff and family member reported to the registered staff that the resident had pain. The registered staff verified that they did not complete a pain assessment when the pain was reported, and no pain management interventions were initiated.

The DOC confirmed that staff were expected to complete a pain assessment when the pain was reported to them.

There was a risk of not managing residents' pain when it was not assessed.

Sources: The resident's clinical records, the home's Pain Management Program Policy, interview with staff members and DOC.

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