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
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: July 26, 2023
Inspection Number: 2023-1440-0007
Inspection Type: Complaint Critical Incident System (CIS)
Licensee: Schlegel Villages Inc.
Long Term Care Home and City: The Village of Humber Heights, Etobicoke

Lead Inspector	**Inspector Digital Signature**
Joy Ieraci (665)	Maria Joy Ieraci Digitally signed by Maria Joy Ieraci Date: 2023.07.28 14:20:09 -04'00'

Additional Inspector(s)
Slavica Vucko (210)

INSPECTION SUMMARY

The inspection occurred on the following dates: July 4-7, 10-14, 17, 2023, and off-site on July 18 and 19, 2023.

The following intake(s) were inspected:

- Log #00088527 (CIS #2957-000018-23) related to medication management and skin and wound care;
- Log #00089954 (CIS #2957-000019-23) related to a fall with injury;
- Logs #00091961 (CIS #2957-000024-23), #00092715 (CIS #2957-000025-23) and #00091971 (Complaint), were related to alleged abuse and skin and wound care;
- Log #00089480 (Complaint) related to plan of care and abuse;
- Log #00090309 (Complaint) related medication management and;
- Logs #00091494 (Complaint) and #00091517 (CIS #2957-000023-23) were related to continence care and skin and wound care.

Inspector #116 was present during this inspection.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Residents' Rights and Choices
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. 3 (1) 19. iv.

The licensee has failed to ensure that every resident has the right to have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

Rationale and Summary

The computer screen attached to a medication cart was observed in the hallway unattended with the screen unlocked. A resident's list of medications was observed. There were no residents, visitors, or staff in the hallway at the time of the observation.

A Registered Practical Nurse (RPN) came out of a resident's room and indicated the computer screen was to be locked when unattended and locked the screen.

The Director of Nursing Care (DNC) indicated that the computer screens were to be locked when unattended to ensure privacy of personal health information (PHI).

There was no risk to residents' PHI when the computer screen was unlocked.

Sources: Observation in one resident home area (RHA) and interviews with the RPN and DNC. [665]

Date Remedy Implemented: July 11, 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 (8)

The licensee has failed to ensure that a registered nurse (RN) who provided direct care to a resident was kept aware of the contents of the resident's plan of care.

Rationale and Summary

The resident's plan of care had instructions on how their medications and fluids were to be prepared for administration to ensure their safety.

An RN attempted to administer the resident's medication and fluids not according to the instructions. A family member stopped the RN from administering the medication. The RN indicated that they did not look at the instructions in the resident's plan of care on how to prepare the resident's medications and fluids for administration.

There was a risk to the resident when the RN was not aware on how to prepare the medication for administration as per the plan of care.

Sources: Review of the resident's clinical records, and interviews with the complainant, RN and other staff. [665]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee has failed to immediately forward to the Director any written complaint that it received

concerning the care of a resident.

Rationale and Summary

The home received a written complaint, regarding the care of a resident.

The Assistant General Manager (AGM) and DNC confirmed that the written complaint was not forwarded to the Director.

The home's complaints process may not be as effective when the written complaint was not immediately forwarded to the Director.

Sources: Review of the written complaint, and interviews with the AGM and DNC. [665]

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

The licensee has failed to ensure that every written complaint made to the licensee concerning the care of a resident received a response within 10 business days of the receipt of the complaint.

Rationale and Summary

A response to a complainant’s written complaint, was not provided.

The AGM and DNC confirmed that a response was not provided to the complainant.

The home's complaints process may not be as effective when a response to the written complaint was not provided.

Sources: Review of the written complaint, and interviews with the AGM and DNC. [665]

WRITTEN NOTIFICATION: SKIN AND WOUND

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)

The licensee has failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown received immediate treatment and interventions to promote healing.

Summary and Rationale

A resident had a history of altered skin integrity. A personal support worker (PSW) noted that there was a new area of altered skin integrity, documented it in Point of Care (POC) flow sheets and reported it to an RPN. The POC system created an alert for registered staff that a skin intervention was required. The Skin and Wound Care Lead was informed two days later, and treatment was not implemented until three days later by the physician.

As per the Physician, they were not made aware about the new area of altered skin integrity on the day it was discovered by the PSW.

Failure of the home to inform the Physician of the resident's new altered skin integrity resulted in a delay of an immediate treatment and interventions to promote healing.

Sources: Review of the resident's clinical records, home's policy Skin and Wound Care, #04-89, dated May 2022, and interviews with the PSW, RPN, DNC and other staff. [210]

WRITTEN NOTIFICATION: SAFE STORAGE OF DRUGS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

Rationale and Summary

On two separate observations, the medication carts in two RHAs were unlocked and unattended.

One medication cart was observed in the hallway and the other cart was in front of the dining room. PSW staff were walking in front of the unlocked medication cart in front of the dining room at the time of the observation.

DNC stated that medication carts were to be locked to ensure safety.

The drugs in the medication carts were not secure when they were left unlocked and unattended by two RPNs.

Sources: Observations in two RHAs and interviews with DNC and other staff. [665]

COMPLIANCE ORDER CO #001 PLAN OF CARE

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

The licensee shall:

1. Develop and implement a process to ensure staff on a specific RHA are trained on how to obtain a specific mobility device for residents when required.

2. Maintain a record of the training conducted, including the trainer, the staff who were trained and the date(s) of the training.

3. Conduct audits weekly for four weeks for a resident to ensure that the correct treatment is provided to their altered skin integrity as per the plan of care, upon service of this order.

4. Conduct audits weekly for four weeks for a resident to ensure that their fall interventions are implemented on the night shift as per the plan of care, upon service of this order.

5. Maintain a record of the audits conducted, including staff who were audited, the auditor, results of the audit and any actions taken to address the audit findings.

Grounds

The licensee failed to ensure that the care set out in the plan of care were provided to two residents as

specified in the plan.

1) Rationale and Summary

The MLTC received a CIS report, regarding improper/incompetent treatment that resulted in harm or risk to a resident.

The resident had an area of altered skin integrity that required treatment. The physician orders had two different treatments for the altered skin integrity based on the presence of a specified characteristic of the area.

An RPN was informed by a PSW that the altered skin integrity required treatment. The RPN indicated that the altered skin integrity did not have the specified characteristic and provided the wrong treatment to the resident.

The DNC confirmed that the RPN applied the wrong treatment to the altered skin integrity and did not follow the plan of care for the resident.

There was a risk that the resident's altered skin integrity could have deteriorated when the treatment orders were not followed as per the plan of care by the RPN.

Sources: Review of the CIS report, the resident's clinical records and home's investigation notes, and interviews with the RPN, DNC and other staff. [665]

2) Rationale and Summary

The home submitted a CIS report to the MLTC regarding an incident that caused injury to a resident for which the resident was taken to hospital and resulted in a significant change in their health status.

The resident was at risk for falls and had multiple falls within two months. The resident had a fall, was transferred to hospital, and sustained injuries.

The resident's plan of care indicated that the resident required a mobility device placed close to them to ambulate, which was implemented 18 days prior to the critical incident.

At the time of the fall, RPN and PSW confirmed that the resident's mobility device was not close to the resident. The PSW stated that the resident's mobility device was in the hallway as it had been cleaned and washed. The PSW stated they were not able to find another mobility device to put beside the

resident.

The Assistant Director of Nursing Care (ADNC) indicated that the PSW should have informed the registered staff to obtain another mobility device from another RHA and, verified that the PSW did not follow the resident's plan of care which contributed to the resident's fall with injury.

Failure to implement the fall intervention for the resident contributed to the resident's fall with injuries and to their significant change in health status.

Sources: Review of the CIS report, the resident's clinical records, interviews with ADNC, RPN, PSW and other staff. [665]

This order must be complied with by September 8, 2023

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
CO #001 issued on October 9, 2020, in Inspection #2020_751649_0017.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By

submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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.