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: November 14, 2023	
Inspection Number: 2023-1440-0010	
Inspection Type: Complaint Follow up	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: The Village of Humber Heights, Etobicoke	
Lead Inspector Adelfa Robles (723)	**Inspector Digital Signature** Adelfa P Robles Digitally signed by Adelfa P Robles Date: 2023.11.27 18:04:59 -05'00'
Additional Inspector(s) Michael Chan (000708)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 31, 2023, and November 1, 2, 3, 6, 7, 2023

The following intake(s) were inspected:

- Intake: #00097415 - Follow-up #1: CO #001-2023_1440_0008: Resident's Bill of Rights. FLTCA, 2021 - s. 3 (1) 19. iv. - CDD October 16, 2023
- Intakes: #00098815 and #00100731 – complaint related to multiple care concerns
- Intake: #00099974 – complaint related to care and alleged abuse

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1440-0008 related to FLTCA, 2021, s. 3 (1) 19. iv. inspected by Adelfa Robles (723)

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

Infection Prevention and Control
Medication Management
Resident Care and Support Services
Residents' Rights and Choices
Reporting and Complaints

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 (8)

The licensee has failed to ensure that staff who provided direct care to a resident were kept aware of the contents of the resident's plan of care.

Rationale and Summary:

A complaint was received regarding a staff not following the resident's plan of care.

A resident's written plan of care indicated the use of a Personal Assistance Service Device (PASD) to assist during care.

A staff provided care to a resident without the use of a PASD. The home stated that the PASD was required to assist the resident during care.

Failure to apply the required PASD as specified in the resident's plan of care increases their risk of losing their muscle ability and be more dependent on staff for care.

Sources: A resident's written plan of care, interviews with complainant and staff.

[723]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #002 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 legal notice concerning the care of a resident. The home's complaint procedure indicated that for complaints alleging harm or risk of harm, home was required to immediately forward the complaint to the Director.

The home confirmed that the legal notice concerning care issues of a resident was not forwarded to the Director.

The home's failure to forward all written complaints to the Director presented minimal risk of harm to the resident.

Sources: Review of Legal Notice received by the home, the home's Complaint Procedure Tab 11-21 and staff interview.

[723]

WRITTEN NOTIFICATION: NURSING AND PERSONAL SUPPORT SERVICES

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

Rationale and Summary

Staff were observed transferring a resident twice with the use of an assistive device with the wheelchair brakes not engaged.

The home's policy stated staff should ensure brakes have been applied to the wheelchair prior to initiating a transfer. The home confirmed that to ensure safe transfer using an assistive device, staff were expected to ensure that wheelchair brakes were engaged prior to transfer.

Failure to ensure that the staff utilized safe transferring and positioning techniques could potentially result in injury to the resident.

Sources: Observations in the home, home's "Mechanical Lifts" policy (04-66A), last revised January 22, 2023, and staff interviews.

[000708]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

The licensee has failed to ensure that the Director was immediately informed of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act using the Critical Incident (CI) Report system.

Rationale and Summary

The home was declared in a confirmed Coronavirus disease (COVID-19) outbreak. The home confirmed that it was reported to the Director the following day.

The home was aware that confirmed outbreaks were required to be reported immediately to the Director.

Failure of the home to immediately inform the Director did not place the resident at risk.

Sources: CI Report and staff interview.

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