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: July 31, 2024

Inspection Number: 2024-1440-0002

Inspection Type:
Complaint
Critical Incident

Licensee: Schlegel Villages Inc.

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 2-5, 8-12, and 15-18, 2024.

The following Critical Incident System (CIS) intake(s) were inspected:
• #00110706 related to improper care of resident;
• #00115493 related to infectious disease outbreaks;
• #00116700 related to falls prevention and management;
• #00118503 related to an incident that caused a significant change in resident's health condition; and
• #00119256 related to neglect of resident.

The following Complaint intake(s) were inspected:
• #00112876, #00113413, #00119459 related to multiple care concerns for resident; and
• #00118806 related to an incident that caused a significant change in resident's health condition.

The following intake(s) were completed:

- #00111032; #00112896 related to infectious disease outbreaks; and
- #00113290 related to falls prevention and management.

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

Continence Care
Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
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 (2)

Plan of care

s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that the care set out in a resident's plan of care was based on the needs and preferences of that resident.

Rationale and Summary:

A resident with cognitive impairment had a family member as their substitute decision-maker (SDM) for care. Record review and interviews with the family and

staff revealed that the resident had a specified care preference that was not provided. A review of the resident's plan of care and interviews with the Neighbourhood Coordinator (NC) and the Director of Nursing Care (DNC) confirmed that the care set out in the resident's plan did not reflect their preference.

Failure to ensure the care set out in the resident's plan of care was based on their preference posed a risk of jeopardizing the resident's well-being.

Sources: Resident's progress notes, profile and move in record, care plan; interviews with the SDM, Registered Practical Nurses (RPNs), NC, and the DNC.
[565]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in two residents' plans of care were provided to the residents as specified in the plans.

Rationale and Summary:
(a) A resident had a specified health risk, and their plan of care specified a dietary intervention.

During an observation, it was noted and verified with the Registered Dietitian (RD) that the intervention was not provided to the resident.

The DNC stated that the dietary intervention should have been provided as specified in the resident's plan for safety and acknowledged that it was not.

Failure to provide the resident with the specified dietary intervention increased their health risk.

Sources: Observation; resident's care plan; interview with the RD and DNC.
[565]

(b) A resident's plan of care specified an intervention for their activity of daily living (ADL). During multiple observations, the resident was not provided with the intervention by a PSW.

Record reviews and staff interviews indicated that the resident had a health risk that required the intervention to minimize the risk. Interviews with the PSW and DNC verified and acknowledged that the resident should have been provided with the intervention, but this was not done.

The failure to provide the intervention increased the resident's health risk during the ADL.

Sources: Observations; resident's care plan; interviews with the PSW, RPN, and the DNC.
[565]

(c) A resident with cognitive impairment had a family member as their SDM for care. Their plan of care indicated that staff should have provided eating assistance due to the resident's health conditions.

Interviews with the family member and a PSW confirmed that during a meal service, the specified eating assistance was not provided. The DNC stated that staff should have followed the resident's plan for providing assistance and acknowledged that it was not provided as specified.

Failure to provide the eating assistance increased the resident's health risk.

Sources: Resident's progress notes, assessment records, care plan; interviews with the family, PSW, Registered Nurse (RN), and DNC.
[565]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to immediately report the information to the Director when they had reasonable grounds to suspect neglect of a resident.

Rationale and Summary:
A resident's SDM reported concerns of neglect to the home. Several days later, the home submitted a CIS report to the Ministry of Long-Term Care.

The DNC confirmed that the incident should have been reported immediately to the

Director and that the CIS report was submitted several days later.

Sources: CIS report; interviews with the DNC.
[740836]

WRITTEN NOTIFICATION: Oral care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 38 (1) (a)
Oral care
s. 38 (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures;

The licensee has failed to ensure that a resident received oral care to maintain the integrity of the oral tissue, including mouth care in the evening.

Rationale and Summary:
A resident's SDM reported concerns related to improper care.

The resident's plan of care indicated that they required assistance with oral care. The home's Oral Care Policy indicated that all residents are to be provided oral care a minimum of twice daily, in the morning and at bedtime, and as required. An investigation by the home concluded that the resident did not receive oral care one evening before sleeping.

The Assistant Director of Nursing Care (ADNC) confirmed that the resident was not provided oral care and there was risk to hygiene and infection.

Failure to ensure the resident received mouth care increased the risk to their oral

integrity.

Sources: Resident's plan of care, home's oral care policy, home's investigation notes; interview with the ADNC.
[740836]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

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

Rationale and Summary:
A resident's SDM reported concerns related to improper care and stated that the resident was improperly transferred by a PSW after providing care.

The resident's plan of care indicated that they required a specified technique for transfers. The home conducted an investigation and concluded that the PSW did not use the specified technique for transfers on multiple occasions on a specified date.

The ADNC confirmed that the resident was transferred by the PSW without using the specified technique and that there was a risk of the resident falling.

Failure to ensure that staff used safe transferring and positioning techniques when assisting the resident increased the risk of falls and injury.

Sources: Resident's care plan, home's investigation notes; interview with the ADNC. [740836]

WRITTEN NOTIFICATION: Continence care and bowel management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee has failed to ensure that a resident's plan of care was implemented to promote and manage bowel and bladder continence.

Rationale and Summary:
A resident's SDM reported concerns regarding continence care provided to the resident.

The resident's plan of care specified the continence care for the resident. An investigation by the home concluded that the resident was not assisted with continence care on the specified dates as outlined in their care plan.

The DNC stated that the resident was not assisted with continence care during the specified period on those days, as per their plan of care.

Failure to ensure the resident's plan of care was implemented to promote and manage bladder continence could increase the risk of altered skin integrity.

Sources: Resident's clinical records, home's investigation notes; interview with the DNC.
[740836]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the infection prevention and control (IPAC) standard for long-term care homes, revised September 2023, was implemented in accordance with the standard. Specifically:
- Additional Precautions section 9.1 (d), directed the home to ensure that their additional precautions shall include evidence-based practices for combined precautions.

Evidence-based practices under the Public Health Ontario's Routine Practices and Additional Precautions In All Health Care Settings, 3rd edition, Provincial Infectious Diseases Advisory Committee (PIDAC) specified that for clients/patients/residents who have a cough or other symptoms of an acute respiratory infection, if single room accommodation is unavailable, maintain a spatial separation of at least two

metres between the coughing client/patient/resident and others in the room and draw the privacy curtain between beds.

Rationale and Summary:
Observations conducted on multiple days revealed that a resident was under additional precautions and was demonstrating symptoms of acute respiratory infection in their shared room. The privacy curtain between the beds was not drawn when both residents were present.

Interviews with a PSW and the IPAC lead confirmed that their IPAC practices required staff to draw the privacy curtain between the beds of a shared room when a resident was in isolation. The staff members confirmed that the resident was under additional precautions on the aforementioned dates and that the curtain should have been drawn for IPAC purposes.

The non-compliance increased the risk of cross-contamination and infection transmission between residents.

Sources: Observations; resident's progress notes; interviews with the PSW and IPAC Lead.
[565]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce

transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that on every shift, symptoms of infectious disease were recorded for a resident.

Rationale and Summary:
Record review and staff interviews revealed that a resident began demonstrating symptoms of an infectious disease and was placed under additional precautions on the same day. Interviews with the IPAC lead indicated that staff were required to monitor the resident's symptoms of infection every shift and document them in Point Click Care (PCC) using the infection surveillance assessment tool. However, during a shift, there was no recorded documentation of the resident's symptoms.

Failure to record symptoms of infection every shift placed the resident at risk of ineffective care planning and potential of delayed interventions.

Sources: Resident's progress notes, assessment records; interviews with the PSW and IPAC Lead.
[565]