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: December 3, 2024
Inspection Number: 2024-1440-0003
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): October 31, 2024, and November 1, 4, 5-8, 12-15, 2024

The following critical incidents (CIs) were inspected:

- Intake: #00121804 - Critical Incident (CI): #2957-000025-24 related to disease outbreak.
- Intakes: #00123082, #00123111 - CIs: #2957-000030-24, #2957-000031-24- Staff to resident abuse.
- Intake: #00125458 - CI: #2957-000038-24 related to a resident sustained injury of unknown cause.
- Intake: #00126355 -CI: #2957-000040-24 - related to unsafe transferring of a resident.

The following complaints were inspected:

- Intake: #00122633 - Was a complaint related to related air temperature in the home.
- Intake: #00125630 - A complaint related to multiple concerns with a resident's care.
- Intake: #00126593 - A complaint related to housekeeping, laundry and maintenance concerns.

The following intakes were completed in this CI inspection:

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- Intake: #00120127 - CI: #2957-000021-24 related to disease outbreak.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Accommodation services

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (a)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;

The licensee has failed to ensure the ceiling tiles, walls and flooring in a shared resident shower room were kept clean and sanitary.

Rationale and Summary

Inspector observation revealed a shower room was not kept clean and sanitary. A housekeeping staff confirmed that they did not clean that room as scheduled and should have.

Failure to ensure that the shower room was kept clean and sanitary may increase the potential for risks associated with infectious diseases, and potentially impacts the residents' right to live in a safe, clean environment.

Sources: Observations, written complaint, interviews with housekeeper, Director of Environmental Services and others.

[000704]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 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 staff used safe transferring techniques when assisting a resident.

Rationale and Summary

The resident's mobility aide was not placed near the resident before their transfer, while the PSW went to retrieved the transportation aide the resident fell.

The Director of Nursing Care (DNC) acknowledged the PSW was to ensure the resident's mobility aide was placed near the resident prior to initiating the transfer.

Failure to use safe transferring techniques while assisting a resident resulted in a fall

with injury.

Sources: A Resident's clinical records, the home's investigation records and interviews with PSW and the DNC.

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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 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee has failed to ensure that on every shift, residents' symptoms indicating the presence of infection were monitored.

Rationale and Summary

Six residents' symptoms were being monitored during an outbreak, on a certain shift, resident's symptoms of infection were not monitored for the six residents .

Infection Prevention and Control (IPAC) Lead confirmed that the symptoms of all six residents were not monitored as required.

Failure of staff to monitor the residents' symptoms of infection every shift placed the

residents at risk of delayed treatment of their symptoms.

Sources: Clinical record review of residents on outbreak surveillance line list; interviews with IPAC Lead and others.

[000704]

WRITTEN NOTIFICATION: CMOH and MOH

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health (CMOH) were followed in the home.

Specifically, the use of Personal Protective Equipment (PPE) recommended by the CMOH based on relevant guidance was in place.

Rationale and Summary

A PSW was observed attending to a resident in a room with additional precautions in place, which included the use of eye protection and an N95 respirator. The PSW did not wear the N95 respirator and eye protection as per the CMOH recommendations.

Failure to wear the appropriate PPE when in close contact with residents who require additional precautions posed a risk for transmission of infectious disease.

Sources: Observations, a resident's clinical records and Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, Ministry of Health, April 2024; and interviews with a PSW and IPAC Lead.

[000704]

COMPLIANCE ORDER CO #001 Duty to protect

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

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

1. Provide education to all registered nursing staff, Personal Support Workers and students on an identified resident home area (RHA) on the types and definitions of abuse and neglect of a resident in accordance with Ontario Regulation 246/22.
2. Maintain documentation of the education, including when the education was completed, who completed the education, who attended and the content of the education completed.
3. Make all records available to inspectors immediately upon inspection.

Grounds

The licensee has failed to protect residents #001 and 002 from abuse from a PSW.

Section 2 of Ontario Regulation 246/22 defines "physical abuse" as (a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Rationale and Summary

i) The home submitted a CI report related to witnessed abuse of resident #002 by a PSW. A student PSW reported that they observed a PSW physically abused resident #002 resulting in pain and injury.

A RPN acknowledged that they saw evidence of injury on resident #002 and reported it to the nurse in charge on the same day.

The DNC confirmed that, following their investigation, the physical abuse to resident #002 by a PSW was substantiated.

Resident #002's safety and well-being were impacted when they were not protected from abuse by a PSW.

Sources: Resident #002's clinical records, CI: #2957-000030-24, Interview with PSW student, a RPN and the DNC.

[000704]

Rationale and Summary

ii) A student PSW reported that they observed a PSW physically abuse resident #001 during care.

The DNC confirmed that, following their investigation, the physical abuse to a resident by a PSW was substantiated.

A resident's safety and well-being were impacted when they were not protected from abuse by a PSW.

Sources: Resident #001's clinical records, CI #2957-000031-24, Interview with a student PSW and the DNC.

[000704]

This order must be complied with by: January 17, 2025

COMPLIANCE ORDER CO #002 Reporting certain matters to Director

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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

Specifically, the licensee must:

1. Provide education to all registered nursing staff, Personal Support Workers and students on an identified RHA on:
    1. The types and definitions of abuse of a resident in accordance with Ontario Regulation 246/22.
    2. The duty to report under section 28 (1) of the fixing Long-Term Care Act, 2021.

2. Keep documented records of the education provided, including the education content, the name of the educator, the names of the attendees, and date of the training.
3. Make all records available to inspectors immediately upon inspection.

Grounds

The licensee failed to immediately report to the Director when a student PSW witnessed abuse by a PSW to two residents.

Rationale and summary

In accordance with s. 28 (1) 2 of the Fixing Long-Term Care Act. pursuant to s. 154 (3) the licensee is vicariously liable for staff members failing to comply with s. 28 (1).

i) In an interview with a student PSW, they indicated they did not report the witness abuse of resident #002 to the home because they were afraid of jeopardizing their placement with the home.

DNC confirmed that the student PSW was required to report any alleged or witnessed abuse to the management and did not report the abuse to the home or the Director immediately.

Failure to report immediately any alleged or witnessed abuse of a resident to the Director put the resident at risk of further abuse.

Sources: CI: #2024-000030-24, LTC home's investigation notes, interviews with a student PSW, DNC and others.

[000704]

Rationale and summary

ii) The LTC home's investigation notes indicated that a student PSW reported to a RPN that they witnessed physical abuse toward a resident weeks prior but failed to

report it to the home. The student PSW indicated they observed a PSW physically abuse resident #001 during personal care.

The DNC confirmed the student PSW was required to report any alleged or witnessed abuse to the management and did not report the abuse to the home or the Director immediately.

Failure to report immediately any alleged or witnessed abuse of a resident to the Director put the resident at risk of further abuse.

Sources: CI: #2024-000031-24, LTC home's investigation notes, interviews with a student PSW, DNC and others.

[000704]

This order must be complied with by: January 17, 2025

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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.