Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 23, 2019	2019_759502_0019	014916-19	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

Long-Term Care Home/Foyer de soins de longue durée

Humber Valley Terrace
95 Humber College Blvd. ETOBICOKE ON M9V 5B5

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JULIENNE NGONLOGA (502)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 8, 9 and 12, 2019, and off-site on August 15, 2019.

The following intake was inspected in this Critical Incident System Inspection:
- log #014916-19, (CIS #2716-000008-19) related to an unexpected death.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (DOC), Behaviour Service Ontario Lead, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Dietary Aide.

During the course of the inspection, the inspector(s) observed staff to resident interactions, resident to resident interactions, and the provision of care, reviewed resident's health records, staffing schedules, the home's investigation notes, the home's camera footage, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Personal Support Services
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for resident #001.

A Critical Incident System report (CIS) was submitted to the Director related to an

unexpected death.

A review of the home's camera footage recorded on an identified date for a specified period, indicated that after dinner service identified food plates were left unattended in an identified care area. RPN #102 was observed a few minutes later leaving a beverage on the same table, and then left the food unattended.

Resident #001 was observed entering the care area and eating from the food left unattended. Subsequently, resident #001 had an unexpected episode and fell. Although staff assisted them promptly after they fell, resident #001 was pronounced dead by the paramedics a few minutes later.

Review of the home's investigation indicated that the food left unattended belonged to resident #002.

A review of resident #002's written plan of care at the time of the incident, directed staff that resident #002 to eat meals at scheduled meal times. Food plates should be removed by the end of meal service, as the resident displays specific responsive behaviour, which is not safe for resident #002 and other residents in the home.

In an interview, PSW #109 indicated that they cleaned up the dining room and left resident #002's food on the table, which was a practice in the home. The PSW stated that they were aware of the resident's plan of care that directed them not to leave food on the table after meal services. The PSW told the inspector that the Administrator reminded staff to take the food off the table by a specific time, they did follow that instruction and one time resident #002 displayed the identified responsive behaviour toward them because the food was not left on the table after the meal service. The PSW stated that after that, they were afraid of resident #002 and continued to leave the food on the table to avoid any responsive behaviours from them.

In an interview RPN #102 indicated that resident #001's routine after meal service was to perform mouth care independently in their room, then request a beverage in the dining room. The RPN stated that they helped the PSW to clean the dinner room after the meal service on the day of incident, they were aware that the PSW had left food on the table, and they did not direct them to remove the food when they left the above mentioned beverage on the table. RPN #102 told the inspector that staff should not leave resident #002's food on the table at any time, as they require supervision with meals and displays the identified responsive behaviour.

In an interview, Behaviour Service Ontario (BSO) lead indicated that staff working on an identified shift informed the BSO team that resident #002 was not compliant with the rules regarding dinning times and was displaying the responsive behaviour toward staff who tried to remove food from the table. The BSO lead directed staff to call Code White when the resident displays responsive behaviour and poses a threat to themselves or other residents, but not to leave food on the table after meal time. They indicated that staff were afraid of resident #002 and would rather leave food on the table and avoid confrontation with the resident, than call Code White. The BSO lead indicated that resident #002's meal encompassed many choices, and that makes the environment unsafe for other residents with different diets and food consistency.

In an interview, the DOC acknowledged that the environment was not safe for the resident as food was left unsupervised in the dining room.

From the review of the home's camera footage, progress notes, home's investigation notes, and staff interviews, staff left food plates for resident #002 unattended in the room, which was unsafe for resident #001. As result resident #001 took food from the plate, ate it, had an unexpected episode and died. [s. 5.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan.

A CIS was submitted to the Director related to an unexpected death.

A review of the home's camera footage recorded on an identified date for a specified period, indicated that after dinner service identified food plates were left unattended in an identified care area. RPN #102 was observed a few minutes later leaving a beverage on the same table, and then left the food unattended.

Resident #001 was observed entering the care area and eating from the food left unattended. Subsequently, resident #001 had an unexpected episode and fell. Although staff assisted them promptly after they fell, resident #001 was pronounced dead by the paramedics a few minutes later.

Review of resident #002's Minimum Data Set (MDS) assessment indicated that the resident has specified responsive behaviours. They were able to perform activities of daily living (ADL) with supervision from staff, and staff should continue to cue them at meal time.

Review of the resident #002's written plan of care indicated that they required supervision for eating as evidenced by their specified responsive behaviour and interventions were implemented, including resident #002 to eat their meals at scheduled meal times and unattended food plates should be removed by end of meal service.

On an identified date and time, the inspector observed resident #002 in the room on the third floor accompanied by a 1:1 staff member. The resident was not served first, and the meal was served one course at the time.

In separate interviews, PSW #112 and dietary aide (DA) #111 indicated that they used to serve the resident all courses at once, but it was not presentable, and they would take part of their meal to the room. The DA indicated that they were currently serving the resident one course at the time to ensure they finished their meal in the dining room.

In an interview, PSW #109 indicated that they cleaned up the dining room and left resident #002's food on the table, which was a practice in the home. The PSW stated that they were aware of the resident's plan of care that directed them not to leave food on the table after meal services. The PSW told the inspector that the Administrator reminded staff to take the food off the table by a specific time, they did follow that instruction and one time resident #002 displayed the identified responsive behaviour toward them because the food was not left on the table after the meal service. The PSW stated that after that, they were afraid of resident #002 and continued to leave the food on the table

to avoid any responsive behaviours from them.

In an interview RPN #102 indicated that resident #001's routine after meal service was to perform mouth care independently in their room, then request a beverage in the dining room. The RPN stated that they helped the PSW to clean the dinner room after the meal service on the day of incident, they were aware that the PSW had left food on the table, and they did not direct them to remove the food when they left the above mentioned beverage on the table. RPN #102 told the inspector that staff should not leave resident #002's food on the table at any time, as they require supervision with meals and displays the identified responsive behaviour.

In a joint interview, the ADOC and DOC acknowledged that the above mentioned PSW and RPN did not provide meal service to resident #002 as per their care plan. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to inform the Director immediately, in as much detail as is possible in the circumstances, of an unexpected death of resident #001 in the home.

A CIS was submitted to the Director related to an unexpected death.

From a review of the CIS report and resident #001's progress notes, on an identified date and time, a loud noise was heard in the dining room. A registered staff went to investigate and found resident #001 laying on the floor with a change in condition. The nursing staff assisted the resident, specified care was provided, and emergency services were called. The paramedics arrived at the scene and cardiopulmonary resuscitation (CPR) was not provided as resident #001 was do not resuscitate (DNR), and they were pronounced dead. The attending physician was informed, and they directed the staff to call the coroner. The CIS report was submitted three days after the incident occurred.

In an interview RN #106, who was in charge of the building at the time of the incident indicated that they informed the Manager on call that day. As per home policy the Manager on call should have reported the incident to the Director or provide guidance to the staff on duty.

In a joint interview, ADOC #106 and DOC #103 stated that the incident mentioned above was reported to the Director three days after the incident occurred. They acknowledged that it was ate reporting. [s. 107. (1) 2.]

Issued on this 26th day of August, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIENNE NGONLOGA (502)
Inspection No. / No de l'inspection :	2019_759502_0019
Log No. / No de registre :	014916-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 23, 2019
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4
LTC Home / Foyer de SLD :	Humber Valley Terrace 95 Humber College Blvd., ETOBICOKE, ON, M9V-5B5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Marjorie Mossman

To Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must be compliant with s. 5 of the LTCHA, 2007.

Specifically the licensee shall ensure:
1. A safe environment for all residents in the home.
2. No food items are left unattended in the dining room.
3. Resident #002 and all other residents who require supervision, are supervised during meal service at all times.

Grounds / Motifs :

1. The licensee has failed to ensure that the home was a safe and secure environment for resident #001.

A Critical Incident System report (CIS) was submitted to the Director related to an unexpected death.

A review of the home's camera footage recorded on an identified date for a specified period, indicated that after dinner service identified food plates were left unattended in an identified care area. RPN #102 was observed a few minutes later leaving a beverage on the same table, and then left the food unattended.

Resident #001 was observed entering the care area and eating from the food left unattended. Subsequently, resident #001 had an unexpected episode and fell. Although staff assisted them promptly after they fell, resident #001 was pronounced dead by the paramedics a few minutes later.

Review of the home's investigation indicated that the food left unattended

belonged to resident #002.

A review of resident #002's written plan of care at the time of the incident, directed staff that resident #002 to eat meals at scheduled meal times. Food plates should be removed by the end of meal service, as the resident displays specific responsive behaviour, which is not safe for resident #002 and other residents in the home.

In an interview, PSW #109 indicated that they cleaned up the dining room and left resident #002's food on the table, which was a practice in the home. The PSW stated that they were aware of the resident's plan of care that directed them not to leave food on the table after meal services. The PSW told the inspector that the Administrator reminded staff to take the food off the table by a specific time, they did follow that instruction and one time resident #002 displayed the identified responsive behaviour toward them because the food was not left on the table after the meal service. The PSW stated that after that, they were afraid of resident #002 and continued to leave the food on the table to avoid any responsive behaviours from them.

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In an interview, Behaviour Service Ontario (BSO) lead indicated that staff working on an identified shift informed the BSO team that resident #002 was not compliant with the rules regarding dinning times and was displaying the responsive behaviour toward staff who tried to remove food from the table. The BSO lead directed staff to call Code White when the resident displays responsive behaviour and poses a threat to themselves or other residents, but not to leave food on the table after meal time. They indicated that staff were afraid of resident #002 and would rather leave food on the table and avoid

confrontation with the resident, than call Code White. The BSO lead indicated that resident #002's meal encompassed many choices, and that makes the environment unsafe for other residents with different diets and food consistency.

In an interview, the DOC acknowledged that the environment was not safe for the resident as food was left unsupervised in the dining room.

From the review of the home's camera footage, progress notes, home's investigation notes, and staff interviews, staff left food plates for resident #002 unattended in the room, which was unsafe for resident #001. As result resident #001 took food from the plate, ate it, had an unexpected episode and died.

The severity of this non-compliance was determined to be level four as there was serious harm/immediate risk to the resident. The scope was determined to be level one as it resulted in unexpected death of one out of three residents reviewed. The home had a level two compliance history as they had previous non-compliance to a different subsection. As a result of serious harm/immediate risk to the resident, a compliance order is warranted. (502)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 23rd day of August, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julienne NgoNloga

Service Area Office /
Bureau régional de services : Toronto Service Area Office