Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 15, 2020	2020_780699_0010	010102-20	Complaint

Licensee/Titulaire de permis

Humber Valley Terrace Operating 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

PRAVEENA SITTAMPALAM (699)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): Onsite May 25, 26, and 28, 2020. Offsite May 27, 29 and June 1, 2020.

The following Complaint log was inspected during this inspection:
Log #010102-20 related to fall prevention, medications/treatments concerns, cleanliness of the home, and notifying power of attorney (POA) of care changes.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Environmental Service Manager (ESM), Infection Prevention and Control (IPAC) Lead, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspector(s) conducted observation of staff and resident interactions and the provision of care, reviewed resident health records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **0 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. 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 care set out in the plan of care was provided to resident #002 as specified in the plan.

The Ministry of Long-term care received an anonymous complaint regarding falls prevention interventions for residents.

Record review of resident #002’s plan of care indicated that the resident was at risk for falls. Further review of resident #002’s plan of care indicated specific interventions for falls prevention.

The inspector made multiple observations of resident #002 on May 25, 26 and 28, 2020. The resident was observed to be in bed with the bed in lowest position and a specific falls prevention device in place. On the above-mentioned dates, the inspector did not observe the resident wearing an identified fall preventions device.

Record review of resident #002's progress notes indicated the resident had a fall with no injury on a specified date. Further review of the progress notes did not indicate whether two of the resident's falls prevention interventions were in place at the time of the fall. Review of the physiotherapist's progress note indicated that the above fall interventions should continue to be in place for the resident.

In an interview with PSW #105 who worked on May 28, 2020, they indicated that it was their first day working with the resident and did not know what fall interventions were in place for the resident. They indicated that the resident did not have an identified fall prevention device in place.

In an interview with RPN #109, they indicated that the resident sometimes refused a specific fall prevention intervention. They further indicated that the resident did not have their specified falls prevention device in place currently and was in the process of installing one for the resident. [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 is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

The inspector conducted multiple observations on May 25, 26 and 28, 2020 throughout the home. The inspector observed the following:

-May 25, 2020: observed PSW #105 in a specified room, standing by resident #001, who is confirmed COVID-19 positive, with no personal protective equipment on. Inspector observed the PSW exit the room without performing hand hygiene until asked by Inspector if they had conducted hand hygiene;

-May 25, 2020: observed a RPN enter a specified room to assist resident #003 who is COVID-19 positive with surgical mask, face shield and gloves on, however no gown on. The RPN exited the room after providing positioning assistance to resident #003 and indicated that they had forgotten to wear an isolation gown in the room;

-May 26, 2020: observed a staff member on the first floor providing nourishment to residents, entering resident rooms with no gloves on to provide residents with fluids. Inspector continued to observe the staff member enter and exit multiple resident rooms without putting on gloves to provide fluids, however they were completing hand hygiene

using hand sanitizer after exiting rooms. The staff member was observed to be wearing the same gown throughout providing nourishment, and only removed gown after completing the nourishment pass. The first floor was noted to have a mix of COVID-19 positive, negative and resolved residents.

-May 26, 2020: observed a staff member on the third floor serving fluids during lunch service. Inspector observed the staff member enter and exit a resident's room multiple times without removing gloves and gown, once to pour fluids into a cup and again to grab packets off the cart without removing gloves. They removed gown and gloves after providing the resident their fluids.

In an interview with PSW #107, they indicated that they were supposed to change gowns and gloves after exiting an isolation room, unless they were going from one COVID-19 positive resident to another COVID-19 positive room after removing gloves and completing hand hygiene. The PSW indicated that they have observed staff entering negative resident rooms without changing their gowns despite having been in a COVID-19 positive room.

In an interview with PSW #110, they indicated that they have observed other staff wearing the same gowns into resolved residents rooms after entering a COVID-19 positive resident room. They indicated that in the hallway, staff are to be wearing surgical masks, face shields, gowns and gloves and when they enter resident rooms, they would wear full PPE and change their gowns and gloves if they are exiting a COVID-19 positive room.

In interviews with RPN #103 and RN #108, they indicated the isolation precautions on the first floor was droplet precautions, which includes wearing face shield, surgical mask, gown, and gloves when entering the resident rooms. RPN #103 indicated that when staff are providing nourishment, they should change their gloves after each resident, perform hand hygiene, and change gowns if going from a COVID-19 positive resident room to a resolved room. They further indicated that the changing of gowns between resolved and positive COVID-19 rooms was not happening as much, however a recent change has been implemented to cohort staff among resolved and positive COVID-19 residents to reduce transmission.

In an interview with IPAC lead #106 indicated that all residents were on droplet isolation precautions. They acknowledged that for the above-mentioned observations, staff did not implement appropriate IPAC practices. [s. 229. (4)]

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 all staff participate in the implementation of the program, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

The inspector conducted multiple observations on May 25, 26 and 28, 2020 throughout the home. The inspector observed that on the third floor and on the second floor, there was the presence of strong urine odour on each of the above mentioned days.

In an interview with PSW #110, they indicated that there has been an issue of an odour on the floor for a while, which could be attributed to the soiled linen cart located in the hall. They were not aware of any interventions or procedures in place to deal with the lingering odor.

Record review of the home's policy, titled "Urine Odour Audit", indicated that if there was a lingering odour identified in the home, the following would be completed:
1. When a concern of lingering urine odour is identified the Urine Odour Audit form must be completed by the ESM. This will include the conclusion and suggested action to eliminate the odours;
2. A copy of the completed Urine Odour Audit will be given to the Administrator/Executive

Director and Director of Care; and
3. A solution to the odour concern will be implemented with corrective action taken, completed date and responsible party recorded on the audit form.

In an interview with ESM #104, they indicated that for the above identified areas, deep cleaning of the identified resident rooms was occurring, including cleaning of the resident's bed, utilizing vinegar on the floor to remove the odour, and cleaning the room twice daily. The ESM indicated that this was implemented prior to the COVID-19 outbreak that was occurring in the home, and had documentation that this deep cleaning was occurring however, there were no records of documentation after March 2020, although the staff were continuing to do the deep cleaning. ESM #104 indicated further that the Urine Odour Audit form was not completed for these above mentioned areas.

The licensee has failed to ensure that the lingering odour procedures was implemented. On three separate dates, the inspector observed strong urine odours on the second and third floor. The home could not provide documentation that the identified locations were deep cleaned as per their process and the Urine Odour audit outlining corrective action and dates of completion was not completed as outlined in the home's policy. Therefore, the home failed to ensure their lingering odour procedure was implemented. [s. 87. (2) (d)]

Issued on this 16th day of June, 2020

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

Original report signed by the inspector.