Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspection Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Toronto District
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Original Public Report

Report Issue Date: January 3, 2023	
Inspection Number: 2022-1212-0001	
Inspection Type: Critical Incident System	
Licensee: Humber Valley Terrace Operating Inc.	
Long Term Care Home and City: Humber Valley Terrace, Etobicoke	
Lead Inspector Rajwinder Sehgal (741673)	**Inspector Digital Signature**
Additional Inspector(s) Reji Sivamangalam (739633)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 8-9, 12-13, 15, 2022

The following intake(s) were completed in this Critical Incident System (CIS) inspection:

- Intake: #00001485 (CI: 2716-000015-22), Intake: #00002850 (CI: 2716-000011-21), Intake: #00003275 (CI: 2716-000012-21), Intake: #00003279 (CI: 2716-000009-21) related to falls.
- Intake: #00012030 (IL-06660-AH/2716-000023-22) related to Improper care to resident resulting in injury.
- Intake: #00003208 (AH: IL-91575-AH/CI: 2716-000010-21) related to injury of unknown cause.

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

Falls Prevention and Management
Resident Care and Support Services
Infection Prevention and Control

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INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that fall prevention interventions were provided to resident #001 and resident #003 as specified in their plan of care related to fall prevention interventions.

Rationale and Summary
i) The resident #001's plan of care indicated that they required specific fall intervention to be applied daily.

On an identified date, resident #001 was observed lying in their bed without the intervention in place.

Personal Care Aide (PCA) #102 acknowledged that the resident #001 did not have the specific fall intervention on. The PCA immediately located resident #001's intervention and applied on the resident.

Director of Care (DOC) #100 acknowledged that resident's plan of care was not followed. They indicated that the staff are expected to ensure the interventions are in place as per the care plan.

Sources: Observations, interview with PCA #102, DOC #100 and other staff.

Date Remedy Implemented: December 12, 2022.

[741673]

ii) Resident #003 required to have their specific intervention within reach as a fall prevention strategy. The resident was observed without the specific intervention within reach.

PCA #112 placed the intervention within the resident's reach after it was brought to their attention by the inspector.

Sources: Observation, Resident #003's care plan, Interview with PCA #112.

Date Remedy implemented: December 12, 2022

[739633]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (a)

The licensee has failed to ensure any surveillance protocols related to Rapid Antigen Test (RAT) issued by the Director for a particular communicable disease or disease of public health significance were complied with.

Rationale and Summary
Observations of the home's IPAC practices related to Rapid Antigen Test (RAT) identified that the tester did not follow the manufacturer's instructions of the RAT device.

The home used SARS-CoV-2 Rapid Antigen Test Nasal Device to conduct surveillance testing. The manufacturer's instructions indicated to read test result at 15-30 minutes. Tester #106 read the results at five minutes and failed to follow manufacturer's directions to read the results at minimum of 15 minutes wait period.

Tester #106 acknowledged that the manufacturer's instructions were not followed. The tester did not wait a minimum of 15 minutes before reading the test result for two staff.

IPAC Lead #101 acknowledged that the tester did not follow the testing protocols according to manufacturer's instructions.

As a result of not following the RAT device's manufacturers' instructions, there was a risk of harm to residents, staff and visitors related to spread of COVID-19 infectious disease.

Sources: Observations, SARS-CoV-2 Rapid Antigen Test Nasal Device manufactures' instructions, interview with Tester #106, IPAC Lead #101 and other staff.

[741673]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that care set out in the care plan was provided to resident #001 as specified in the plan.

Rationale and Summary
A Critical Incident System (CIS) reported that resident #001 incurred an injury as a result of staff failure to follow their care plan.

Record review of resident #001's care plan indicated that the resident required an identified level of assistance for Activities of Daily Living (ADLs) tasks.

A review of the home's investigation notes identified that resident #001 had sustained injuries when care was provided in a manner not consistent with the required level of assistance.

In an interview with PCA #103 stated that they have provided care to resident #001 in a manner not consistent with their care plan and left the resident unattended. PCA #103 was aware of the resident's care plan and confirmed that the care plan was not followed.

DOC #100 confirmed that the resident always required a specified level of assistance for their ADLs. They acknowledged that resident #001's care plan was not followed as required.

There was risk and harm to the resident when the care plan was not followed.

Sources: CIS report, resident #001's clinical records and progress notes, interview with PCA #103, DOC #100 and other staff.

[741673]

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

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 System (CIS).

Rationale and Summary
A CIS was submitted to the Director related to confirmed outbreak on December 11, 2022.

The confirmed outbreak was not reported to the Director immediately and was reported one day later.

The IPAC Lead #101 was aware that the confirmed outbreak was required to be reported immediately and confirmed that the Director was not notified immediately.

Sources:
CIS report, interviews with IPAC Lead #101, and other staff.

[741673]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (8)

The licensee has failed to ensure that staff participated in the implementation of the home's Infection Prevention and Control (IPAC) program related to Personal Protective Equipment (PPE).

Rationale and Summary

i) The home's document titled 'N95 Respirator Strategy for Staff' directed all health care workers providing direct care or interacting with a suspected, probable; new move in, or confirmed cases of the disease to wear a fit tested, seal-checked N95 respirator.

Resident #005 was on additional precautions.

During the observation made on an identified date, PCA Student #110 provided assistance to resident #005 without wearing a N95 respirator.

In an interview with PCA student #110, they confirmed that they did not wear N95 respirator while providing nourishment to the resident #005. PCA student #110 was unaware that they had to wear N95 respirator with suspected outbreak cases.

IPAC Lead indicated that all staff including students were directed to wear N95 respirators for confirmed and suspected outbreak cases.

ii) Resident #005 required additional precautions to enter their room. Donning/Doffing posters were posted to provide visual messages about recommended additional precautions and sequence for putting/removing PPEs.

During the observation, PCA student #110 was noted incorrectly don and doff recommended PPEs upon entering and exiting resident #005's room. PCA student #110 was unaware that the order they donned and doffed their PPEs was incorrect.

In an interview with Registered Nurse (RN) #111, they indicated that the resident #005 was on additional precautions, which includes wearing face shield, N95 respirator, gown, and gloves when having contact with the resident. RN #111 indicated that when student was providing assistance, they should have followed correct order of donning and doffing.

IPAC lead #101 in an interview acknowledged that for the above-mentioned observations, PCA student #110 did not implement appropriate IPAC practices.

There was risk of COVID-19 infectious disease transmission when the appropriate PPEs were not worn, and correct donning/doffing procedures were not followed.

Sources: Review of Minister's Directive: COVID-19 response measures for LTCHs, effective April 30,

2022, COVID-19 Guidance Document for LTCHs in Ontario, Donning/Doffing PPE signages, home's Additional Precautions policies and procedures, interviews with IPAC Lead, PCA student, RN, and other staff.

[741673]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with s. 6 (4) (a) of O. Reg. 79/10 under the Long-Term Care Homes Act (LTCHA), 2007 and s. 6 (4) (a) of O. Reg. 246/22 under Fixing Long Term Care Homes (FLTCA) Act 2021.

On April 11, 2022, the FLTCA and O. Reg. 246/22 came into force, which repealed and replaced the LTCHA and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 6 (4) (a) of LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 6 (4) (a) of FLTCA.

Non-compliance with: FLTCA, 2021 s. 6 (4) (a)

i) The licensee has failed to ensure that staff collaborated with each other in the resident #004's assessments when an injury was suspected.

Rationale and Summary
Resident #004 was not ambulatory. On an identified date, PCA #115 and #112 noticed a change in the resident's condition and informed RN #118. The resident's progress notes indicated RN #118 verbally communicated to the nurse practitioner that the resident required an intervention, but the intervention was not ordered. There were no assessments completed to rule out injuries and no referrals were made.

There were further changes in the resident's condition and an intervention was eventually provided and indicated an injury for which the resident required hospitalization.

The DOC and Associate Director of Care (ADOC) acknowledged that staff did not complete the required assessments and referrals when an injury was initially suspected, which delayed the resident's diagnosis and treatment.

Sources: CIS report, resident #004's progress notes and skin assessments, home's investigation notes, interviews with PCA #115, DOC and ADOC.

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ii) The licensee has failed to ensure that resident #003's post-fall assessments were not integrated and complemented each other.

Rationale and Summary
On an identified date, resident #003 had an unwitnessed fall and had a change in their condition after the fall. The resident developed further changes in their condition and developed further injuries. The physician was not informed about the resident's condition.

Physiotherapist (PT) #113 stated that they informed RPN #114 that the resident would require an intervention to further assist in their assessment of the resident's injuries.

The physician was notified on a later date and ordered the intervention. The result of the intervention showed a specific injury, and the resident was sent to the hospital.

RPN #114 verified that they were expected to notify the physician after the assessments revealed an injury and when there was a change in resident’s condition following the fall.

The DOC acknowledged that the assessments were not integrated after the resident’s fall, which resulted in delayed treatment.

Sources: CIS report, resident #003's post fall assessments and progress notes, interviews with PT #113, RPN #114 and DOC.

[739633]