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: February 21, 2024

Inspection Number: 2024-1212-0001

Inspection Type:
Critical Incident

Licensee: Humber Valley Terrace Operating Inc.

Long Term Care Home and City: Humber Valley Terrace, Etobicoke

Lead Inspector	**Inspector Digital Signature**
Jack Shi (760)	Jia J Shi Digitally signed by Jia J Shi Date: 2024.02.22 14:56:16 -05'00'

Additional Inspector(s)
Michael Chan (000708)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: February 13, 14, 15, 16, 2024
The inspection occurred off-site on the following date: February 20, 2024

The following intake(s) were inspected:

- Intake: #00100515, 00103652, 00107900 - 2716-000018-23, 2716-000023-23, 2716-000001-24 - related to disease outbreaks
- Intake: #00101820, 00101969 - 2716-000021-23, 2716-000022-23 - were related to allegations of improper resident care resulting in injury
- Intake: #00105263 - 2716-000026-23 - was related to an incident of resident harm resulting in significant change of status

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

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Safe and secure home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee failed to ensure that the home is a safe and secure environment for its residents, when resident #003 ingested contents from a product that was left within their reach.

Rationale and Summary
Personal Support Worker (PSW) #105 found resident #003 with a product and it had appeared that the resident ingested contents from the product. They removed the product away from the resident and reported the incident to Registered Nurse (RN) #106. The resident's health status declined upon assessment by RN #106. Further medical interventions were provided to the resident following the discovery of the incident.

PSW #105 indicated that staff left the product within the resident's reach. Assistant Director of Care (ADOC) #115 confirmed that the product should not have been left within the resident's reach and that the home did not provide a safe and secure environment for the resident.

Failure to remove the product within resident #003's reach resulted in them ingesting it and compromising their health.

Sources: Interview with the home's staff, resident #003's clinical record, interview with the home's management.

[000708]

WRITTEN NOTIFICATION: Late reporting of an allegation of improper care towards a resident resulting in harm

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that an alleged incident of incompetent or improper treatment of resident #002 that resulted in harm was immediately reported to the Director.

Rationale and Summary
A Critical Incident Systems (CIS) report was submitted related to an injury that occurred with resident #002 after they were involved in an activity that was provided by Recreational Staff (RS) #101. RN #117 stated they were made aware of the incident from the resident a day before the CIS was submitted to the Director. Associate Director of Care/Wound Care Champion (ADOC/WCC) #118 stated that a CIS report should have been immediately submitted following RN #117's discovery of the resident's injuries and how it had occurred.

Sources: CIS report 2716-000022-23, Interviews with RN #117 and ADOC/WCC #118. [760]

WRITTEN NOTIFICATION: Failure to follow home's foot care policies

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 39 (1)
Foot care and nail care
s. 39 (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

The licensee has failed to ensure resident #002 received foot care from a qualified foot care provider or the nurse.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that residents receive preventative and basic foot care services. Specifically, staff did not

comply with the policy "LTC- Bath and Shower Guidelines". The policy states that all residents with a specific diagnosis will receive foot care from a qualified foot care provider or the nurse.

Rationale and Summary

A CIS report indicated that resident #002 developed injuries after being involved in an activity. RN #117 stated they were made aware of the incident after they spoke with the resident whom stated that it was potentially caused by an activity the resident was involved in. The RN confirmed that after they spoke with the physician, they had determined that the potential cause of the resident's injury was from the activity. RS #101 confirmed they did not receive any education or training on providing foot care to residents such as resident #001. ADOC/WCC #118 confirmed that the resident should not have been involved in this program because as per the home's policies, this resident should not have received foot care from staff who are not qualified to provide this type of care.

Failure to ensure that foot care was provided to resident #002 by qualified staff and in accordance with the home's policy caused the resident injuries.

Sources: CIS report 2716-000022-23, Home's investigation notes, Resident #002's electronic records, LTC- Bath and Shower Guidelines policy (dated March 2023), Interviews with RS #101, RN #117, ADOC/WCC #118 and other staff. [760]

WRITTEN NOTIFICATION: Failure to use safe positioning techniques on a resident

NC #004 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 failed to ensure PSW #100 used safe positioning techniques during resident #001's personal care.

Rationale and Summary
The home's investigation notes had indicated resident #001 sustained an injury after PSW #100 provided personal care that did not align with their care plan. The PSW acknowledged they did not provide personal care in a manner that aligned with their care plan.

ADOC #115 stated that PSW #100 should have used safe positioning techniques during resident #001's personal care, which was indicated in the resident's care plan and confirmed that this did not occur in this incident.

Failure to use safe positioning techniques for resident #001 resulted in them sustaining injuries.

Sources: CIS report #2716-000021-23, home's investigation report, resident #001's care plan, Interviews with PSW #110, RPN #111, ADOC #115 and other staff. [760]