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: July 17, 2024
Inspection Number: 2024-1212-0002
Inspection Type: Complaint Critical Incident
Licensee: Humber Valley Terrace Operating Inc.
Long Term Care Home and City: Humber Valley Terrace, Etobicoke

Lead Inspector	**Inspector Digital Signature**
Nicole Ranger (189)	Nicole S Ranger Digitally signed by Nicole S Ranger Date: 2024.07.25 15:29:23 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 6, 7, 10 -14, 17, 20, 21, 2024
The inspection occurred offsite on the following date(s): July 2, 2024

The following intake(s) were inspected:

- Intake: #00110414 -Critical Incident System (CIS) #2716-000005-24 - related to Outbreak Management
- Intake: #00114758 - CIS #2716-000010-24 - related to Fall Management and Prevention
- Intake: #00115372 - CIS # 2716-000012-24 - related to Skin and Wound Care
- Intake: #00115815 - Complaint related to Housekeeping and Maintenance Services
- Intake: #00112340 - Complaint related to Resident Care and Support services,

Certification of nurses

The following intakes were completed during this inspection

Intake: #00110489 - CIS # 2716-000006-24 - related to Fall Prevention and Management

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that the staff collaborated with each other in the implementation of the plan of care for resident #001 related to a significant injury.

Rationale and Summary

The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care (MLTC) related to incident of injury which resulted in a significant change in resident #001's status.

Resident #001 sustained a fall and exhibited pain to an identified body part. An x-ray was ordered by Physician (MD) #007. X-ray results shown a significant injury to an identified body part. The following occurred after the notification of the injury:

i) On an identified date, MD #107 requested that a referral be faxed to a specialized clinic and that the body area be immobilized.

ii) On an identified date, Registered Practical Nurse (RPN) #108 was informed by the clinic that the referral should come directly from a specific specialist.

iii) On an identified date, MD #107 requested another referral to be sent to a specific specialist. Once the referral was sent, the registered staff attempted to contact the specialist, however, the staff documented in the progress notes that the phone line was busy or that no one was answering the phone.

iv) On an identified date, Registered Nurse (RN) #109 communicated with the specialist's office who stated that the referral was re-faxed back to the home the following day after it was received, stating that the referral was not appropriate for the office.

v) On an identified date, the family members of Resident #001 requested the transfer to the hospital, where they received treatment for the significant injury.

RPN #108 stated resident #001 was exhibiting pain and did not have a treatment device in place since the initial notification of the injury. RPN #108 stated that although the nurses tried to get in touch with the specific specialist's office about the status of the referral, they did not follow up with MD #107 to let them know about the referral delay.

MD #107 stated that they were not notified of the delay in reaching the specific specialist's office by the nurses. The MD stated that the nurses should have contacted them if they did not receive an answer from the clinic within 2 days so that they could explore other options or sent the resident to the hospital.

The Director of Care (DOC) #101 acknowledged that the Registered staff were expected to collaborate with the MD to ensure interventions were implemented to manage resident #001's injury.

Staff failure to collaborate with each other put resident #001 at risk of not receiving effective treatment to manage their injury.

Sources: Review of resident #001's clinical records, CIS #2716-000010-24, interviews with MD #107, RPN #108, RN#109, ADOC #105, DOC #101 and other staff.

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WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that resident #001 was reassessed and plan of care was reviewed and revised when the resident's care needs changed.

Rationale and Summary
Resident #001 had a history of falls and sustained a fall on an identified date. The resident was sent to hospital later that day and returned from hospital seven days later.

The home's "Resident Assessment and Plan of Care" policy indicated that interdisciplinary assessments and plan of care reviews were required upon returning from hospital. A readmission referral was sent to the physiotherapist for an assessment of the resident upon return from hospital. The resident's progress notes and clinical records revealed that the physiotherapy assessment was not completed.

Physiotherapist (PT) #111 reported that upon readmission from hospital, a PT assessment is conducted to ensure strategies and interventions are updated and acknowledged that the PT assessment was not completed for the resident, post hospitalization.

Failure to ensure the resident was reassessed, and the plan of care reviewed when the resident's care needs changed increased the risk not implementing an interdisciplinary care plan.

Sources: Review of resident #001 progress notes and clinical record, home's policy titled "Resident Assessment and Plan of Care" CARE1-P10, last reviewed March 31, 2024, interview with PT #111 and other staff.

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WRITTEN NOTIFICATION: HOUSEKEEPING

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

The licensee has failed to ensure that procedures were developed and implemented for cleaning of the home, including privacy curtains.

Rationale and Summary
During a tour of the home, the inspector found the following housekeeping issues. These concerns were brought to the attention of the Environmental Service Manager (ESM) #102 and Executive Director (ED) #100 during a brief tour.

A) Unclean privacy curtains

The home's "Privacy Curtain Changing" policy stated the privacy curtains should be

checked daily for spots, spills and general soiling and replaced when soiled. Curtains should be routinely changed monthly.

Housekeepers #110, #112 and #113 reported if they observed privacy curtains that required cleaning or if they encountered areas that required maintenance attention, they would write on a scrap paper or verbally tell the ESM or the nurse on the unit about the issue. The housekeepers reported they did not complete a formal documentation.

The inspector requested a preventative maintenance schedule and documentation for privacy curtains. The ESM acknowledged that there was no current schedule in place or documentation for preventative maintenance at the time of this inspection and could not identify when the last scheduled cleaning of privacy curtains was conducted.

During observations with the inspector, the ESM and ED acknowledged the housekeeping issue mentioned.

Not ensuring that the privacy curtains were changed monthly and when needed posed a potential risk of spreading harmful microorganisms throughout the home.

Source: Observation on June 11, 2024, home's policy titled "Privacy Curtain Changing" ES-C-10-55 last revised February 1, 2022, interview with ESM #102 and ED #100 and other staff.

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WRITTEN NOTIFICATION: HOUSEKEEPING

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (ii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

The licensee has failed to ensure that as part of the organized program of housekeeping, that procedures were implemented for the cleaning and the disinfection of a resident's assistive device.

Rationale and Summary
Observations noted three residents' wheelchairs were visibly soiled. Resident #002's wheelchair was visibly soiled with heavy buildup of dirt, dried food and liquids, particles, crumbs, and smudges of unknown substances. Resident #006's and #007's wheelchair seats were also visibly soiled.

RPN #114 observed wheelchairs for the residents and acknowledged they were not clean. The RPN stated wheelchair cleaning was to be done on night shift by Personal Support Workers (PSW).

Review of the Point of Care (POC) task for resident #002 noted that the wheelchair was scheduled to be cleaned weekly during the night shift by PSW staff. According to the POC task wheelchair cleaning documentation, resident #002's wheelchair had been signed off as not cleaned by PSW #115 for over one month. PSW #115 confirmed that resident #002's wheelchair was scheduled to be cleaned every week, and acknowledged that they had not cleaned the resident's wheelchair since the time an external company came in to power wash and steam all residents wheelchairs.

Infection Prevention and Control (IPAC) Lead # 103 reported that an external company came into the home and power cleaned all residents assistive devices. IPAC Lead #103 reported that once the company cleaned the assistive device, a sticker would be placed on the assistive device indicating the month and year it was cleaned. Observation of resident #002's wheelchair did not locate the sticker that it was cleaned by the company. IPAC lead #103 reported that they were unsure if the resident's wheelchair was cleaned by the company on that date.

The DOC #101 and IPAC Lead #103 reported that staff were expected to clean wheelchairs, at minimum, once a week and document the completion of the task in POC. The IPAC Lead acknowledged that the wheelchairs had not been cleaned as required.

Failing to clean and disinfect ambulation aids could potentially risk infectious organisms being transmitted through the home.

Sources: Observations of the resident #002, #006 and #007's wheelchairs, review of POC task documentation, interviews with PSW #115, RPN #114, IPAC Lead #103

and the DOC #101.

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WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that on every shift, symptoms indicating the presence of infections in residents #008, #009 and #010 were monitored and recorded.

Rationale and Summary
The home was in a Respiratory outbreak during an identified time period . The home required staff to monitor symptoms indicating the presence of infections and obtain vital signs on every shift on for the affected residents.

The public health line listing identified the onset of first symptoms for residents #008 and #009 and #010 were on identified dates. All residents were placed on additional precautions accordingly. Record review of each resident's progress notes showed that symptoms indicating the presence of infections including vital signs were not documented every shift.

The DOC #101 and IPAC Lead #103 both indicated that symptoms indicating the presence of infections with vital signs should have been monitored every shift and documented in residents' progress notes. IPAC Lead #103 acknowledged that there were missing monitoring documentation for identified residents.

Failure to record the resident's infectious symptoms including vital signs every shift may hinder staff from monitoring the resident's treatment status.

Sources: Review of resident # 008, #009 and #010 progress notes, public health line listing, CIS #2716-000005-24; interview with DOC #101, IPAC Lead #103 and other staff.

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COMPLIANCE ORDER CO #001 MAINTENANCE SERVICES

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)
Maintenance services
s. 96 (1) As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance.

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

1. Repair wall damage identified in the grounds below and in any other resident rooms as required.
2. Repair floor damage identified in the grounds below and in any other rooms as required.
3. Repair exposed cable outlet and wall radiator identified in the grounds below and in any other resident rooms as required.
4. Repair or replace chipped countertop identified in the grounds below and in any other areas in the home as required.
5. Provide a date to have the hard floors in the home stripped.
6. Provide a date with a specific plan on when the elevator (passenger 1 and passenger 2) interior replacement will be completed.
7. Develop room specific audits that includes resident bedrooms, resident ensuite washrooms, dining rooms, activity rooms, so that all furnishings, surfaces, devices and equipment in that area are checked for condition. Include the auditor's name, date audit completed, specific area being audited, the details of the unsatisfactory condition identified, an area to complete, the follow up action and the follow up completion date on the audit form. The audit and documentation of follow up action(s) shall be made available for review for future follow up inspections.
8. Create an updated Deep Cleaning schedule of resident rooms and provide the updated schedule to housekeeping staff.
9. Create a written schedule, outlining the preventative maintenance (PM) requirement under s. 96 (1) b. of O. Reg 246/22, for the maintenance of the home, including but not limited to walls, painting, floors, deep cleaning of rooms. The schedules and documentation shall be made available for review for future follow up inspections.

Grounds

The licensee failed to ensure that schedules and procedures were in place, for

routine, preventative and remedial maintenance.

O. Reg. 246/22, s. 96. (1) (b) requires the licensee to ensure that schedules and procedures were in place for routine, preventative and remedial maintenance.

The following areas of the home were noted to be in poor repair during the inspection:

- Damaged walls that require repair
- Exposed open cable outlet
- Chipped sink countertop
- Window curtain falling from window rod and pinned to the wall
- Water damage creating bubble to paint in bathroom
- Floor damage around toilet
- Damage to wall and flooring at bath door
- Peeling baseboards in washroom
- Black spots on floor underneath wall mounted hand sanitizer in hallways
- Peeling wall paper at window across an identified room
- Storage of a bed and chair inside a resident room
- Orange rust stains on floor underneath tables in an identified unit tv room/dining area
- Baseboard wall radiator broken
- Heavy black scuff marks were noted along a unit hallway
- Broken wall paneling and bumper rails in the elevators.

Discussion with the ESM revealed that the elevator damage was a long-standing issue which required repair and approval from management.

Maintenance staff #116 reported that the hard floors on the units required stripping, and that the floors had not been stripped in the past 5 years. Maintenace staff #116

reported that the previous ESM outsourced an external company to have the hallway and resident room hard floors stripped every three years. Maintenance staff #116 reported that there is a buildup of rust on the hard floors underneath the dining tables on an identified unit, and the black spots caused by the wall mounted alcohol-based hand rub (ABHR) cannot be removed by waxing or polishing.

Housekeeper #113 reported that previously, there was a weekly deep cleaning schedule for resident rooms, and that they have not conducted weekly deep cleaning of resident rooms daily, unless asked to do so by the ESM. Housekeeper #112 and #117 reported that they do deep cleaning of the resident rooms, however the weekly deep cleaning schedule is outdated or not in place.

Maintenance staff #118 member reported that they were the person who looked after preventative maintenance in the home. The Maintenance staff reported that they briefly check the resident rooms to audit if any repairs are required, however they stated they did not have a formal process in place and would document areas that need to be repaired on a scrap paper. The Maintenance staff reported that they would complete job tasks that were entered in the maintenance request care system.

ESM #102, reported that they relied on housekeeping and nursing staff to report when there was damage to the walls or any maintenance issues. The maintenance logs for all floors were reviewed between April 2024 through to the date of inspection, and did not include any entries by staff regarding the observations identified during this inspection.

The inspector requested a preventative maintenance schedules for painting, walls, and flooring. The ESM #102 acknowledged that there was no current schedule in place for preventative maintenance at the time of this inspection. When any issues

arose with maintenance, staff were to notify the maintenance department or enter into maintenance request care system, however this was not routinely done.

During a brief tour of the first floor with ESM#102 and ED #100, the ESM and ED acknowledged the above-mentioned concerns identified were accurate.

Failure to ensure that schedules and procedures were in place, for routine, preventative and remedial maintenance for walls, flooring, furniture and electrical posed safety risks for residents.

Sources: Complaint intake #00115815, Observation on June 6, 11, 13, 2024, maintenance care log, interviews with Housekeeper #112, #113 and #117, Maintenance Staff # 116, #118, ESM #102, ED #100 and other staff.

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This order must be complied with by September 13, 2024

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

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.