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

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Public Report

Report Issue Date: November 27, 2024
Inspection Number: 2024-1212-0004
Inspection Type: Complaint Critical Incident
Licensee: Humber Valley Terrace Operating Inc.
Long Term Care Home and City: Humber Valley Terrace, Etobicoke

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 19, 20, 21, 22, 2024

The following Complaint intake(s) were inspected:
· Intake: #00124697 - Related to concerns of resident-to-resident verbal/emotional abuse

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: BEDTIME AND REST ROUTINES

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 45
Bedtime and rest routines
s. 45. Every licensee of a long-term care home shall ensure that each resident of the home has the resident's desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

The licensee has failed to ensure a resident's rest routines were supported and individualized to promote sleep.

Rationale and Summary
A resident's sleep was disturbed by noise coming from a co-resident's side of the shared room. They indicated that staff had been informed of this issue and were unaware of any actions taken to resolve it. The resident's clinical records indicated an intervention to be in place to promote sleep, which was not being followed.

Multiple sources confirmed noise from the co-resident's side of the room occurred overnight.

Failing to ensure the resident's rest routines were supported and individualized resulted in them having disturbed sleep.

Sources: Residents' clinical records, Interviews with the resident and a Registered Nurse (RN).

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure actions were taken for a resident's responsive behaviour that included assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Rationale and Summary
A family member sent multiple emails to the Resident Services Coordinator (RSC) indicating a resident's actions were disturbing a co-resident's sleep.

The resident's clinical records indicated a referral for this issue was first sent to the home's Behavioural Supports Ontario (BSO) lead after the home had already received multiple complaint emails, which triggered a series of assessments and interventions to be put in place.

Over a specific period of time, staff audited a specific intervention. Multiple entries indicated the intervention was not place. An RN acknowledged the process in implementing the intervention was ineffective.

The co-resident confirmed their sleep was frequently disturbed and that staff had been informed of the issue but were unaware of any actions taken to resolve it.

In failing to ensure actions were taken when the home was first informed of the noise disturbance impacting the co-resident's sleep and reassessing when interventions were found to be ineffective, the co-resident's sleep continued to be disturbed.

Sources: Email correspondences, resident's clinical records, Interviews with co-resident and an RN.

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to ensure that when written complaints were made to the home concerning the care of a resident, the responses provided to the family member included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman.

Rationale and Summary
A family member sent multiple emails to the RSC indicating a care concern for a resident.

The Director of Care (DOC) confirmed that in the RSC's email responses, they did not inform the family member of the contact information to the Ministry of Long-Term Care (MLTC) and patient ombudsman.

Failure to provide the family member with contact information to the MLTC and patient ombudsman upon receiving written complaints related to resident care, resulted in a lack of transparency for how the family member could seek an independent review of their concerns.

Sources: Email correspondences, Interview with DOC.

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. iii.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

The licensee has failed to ensure that when complaints were made to the home concerning the care of a resident, the responses provided to the family member included if the licensee was required to immediately forward the complaint to the Director.

Rationale and Summary
The DOC confirmed that in the RSC's email responses, they did not inform the family member if the complaints were required to be forwarded to the Director.

Failure to inform the family member if their complaint was forwarded to the Director, resulted in a lack of transparency in whether oversight was to be provided

on managing the complaint.

Sources: Email correspondences, Interview with DOC.