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
Feb 28, 2022	2022_769646_0002	001614-22	Proactive Compliance Inspection

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

IVY LAM (646), JULIEANN HING (649)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Proactive Compliance Inspection.

This inspection was conducted on the following date(s): January 31, 2022; February 1, 2, 3, 4, 7, 8, 9, and 10, 2022.

Log #001614-22 related to the Proactive Compliance Inspection was completed.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Directors of Care (ADOCs), Skin and Wound Lead, Education Lead, Clinical Lead for Falls/Pain/Transfers, Environment Services Supervisor (ESS), Maintenance Staff, Nutrition Manager (NM), Recreation Manager, Registered Dietitian (RD), Registered Nurses (RNs), Infection Prevention and Control (IPAC) Manager, Social Service Worker, Registered Practical Nurses (RPNs), Office Manager, Personal Support Workers (PSWs), Dietary Aides (DAs), Housekeeper, Screener, Members of the Residents' Council and Family Council, Residents and Family Members.

During the course of the inspection, the inspectors observed meal and snack service, medication administration, Infection Prevention and Control (IPAC) Practices, Residents' care areas, and reviewed residents' and home's records and pertinent home policies.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **5 WN(s)**
- **5 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).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in resident #005 and #007's plan of care was provided to the resident as specified in the plan.

A) At a mealtime, resident #005 received one cup (125 ml) of a thickened beverage, one cup (125 ml) of another thickened beverage, and one (200 ml) cup of a third thickened beverage. The 125ml cups were three-quarter filled.

The resident required assistance with meals and beverages, and was at high nutritional risk. The Nurse Manager (NM) and Registered Dietitian (RD) indicated that all residents received a fixed amount of fluids at the mealtime: 250 ml of milk; 250 ml of water or juice and 200 ml of coffee or tea unless otherwise specified in their plan of care.

The Personal Support Worker (PSW) stated that resident #005 was served 125 ml less fluids during the observed meal, due to recent changes in cup sizes that they were not aware of.

The NM indicated that the planned menu fluids that resident #005 should receive at lunch consisted of 125 ml of milk, 250 ml of water and 200 ml of tea or coffee. They acknowledged that resident #005's plan of care was not followed when they were provided 125ml less fluids during the above mentioned observation.

The RD indicated that the decreased fluid intake could put the resident at risk of dehydration.

B) Resident #007's plan of care indicated they required supervision while eating or drinking. The resident's progress notes indicated the resident had identified behaviours at mealtimes and staff were to monitor the resident during meals.

Resident #007 was served an entrée of an identified diet texture in their room, and was observed to feed their own food to their co-resident, resident #002. Resident #002 required a different diet texture than resident #007. This observation was immediately brought to a PSW's attention. Failure of staff to supervise resident #007 while eating put resident #002 at risk of choking.

The Director of Care (DOC) advised that staff should have provided supervision to resident #007 during the meal.

[Sources: A) Observation of resident #005's fluid intake, review of resident #005's clinical records, home's menu; interviews with Registered Practical Nurse (RPN), Director of Care (DOC), Registered Dietitian (RD) and other staff.

Sources: B) Observation of residents #002 and #007 at mealtimes, review of resident #002 and #007's clinical records, and interviews with DOC and other staff.] [s. 6. (7)]

2. The licensee has failed to ensure that a resident was reassessed and the plan of care was reviewed and revised when care set out in the plan was no longer necessary.

A resident was at significant risk for falls and had two identified falls prevention interventions when they were in bed.

Observation of the resident's room showed the resident did not have the complete set of the first falls prevention intervention, and the second falls prevention intervention was non-functional.

The RPN told the inspector that the resident no longer required both of the falls prevention interventions, but the plan of care had not been revised to reflect the change in care needs.

[Sources: Observations of the resident; Review of resident #006's clinical records,

interviews with PSW, RPN, RN, and DOC.] [s. 6. (10) (b)]

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, and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that written policies and protocols included in the medication management system were complied with for three residents.

O. Reg. 79/10, s. 114(3) (a) requires that written policies and protocols must be developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

O. Reg. 79/10, s. 136 (1) (a) requires as part of the medication management system, that a written policy is developed in the home that provides for ongoing identification, destruction, and disposal of all expired drugs.

Specifically, staff did not comply with the home's medication administration policy, which indicated expired medication should not be administered and should be removed for disposal.

A) On February 1, 2022, observation of drugs in the medication cart on a resident home area identified the following:
(i) One resident's topical medication had an open date of December 27, 2021, and a discard after date of January 27, 2022.
(ii) A second resident had a topical medication as needed (PRN) with an open date of December 30, 2021, and a discard after date of January 30, 2022.

The RPN immediately removed the expired medications from the medication cart to prevent administration to residents.

B) On February 1, 2022, observation of safe storage of drugs in the medication cart on a resident home area identified the following:
(i) A resident's medication had an expiry date of October 2021.

The RPN acknowledged that the resident's medication had expired. The DOC indicated that the above policy was not followed.

[Sources: Observation of drug storage area on the medication carts on home areas, review of home's Medication Administration policy, interviews with RPNs and DOC.] [s. 8. (1) (b)]

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 plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperatures required to be measured were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

A resident indicated that they were often cold in their room.

Temperatures record for the resident's room showed the following:
- The temperature was recorded three times in the month of January, 2022, and the recorded temperature showed 23 degrees Celsius (C) for two of the three days.
Temperature records for two other residents' rooms showed the following:
- The second room was at 22 degrees C for one evening.
- The third room was at 22 degrees C for six times in January.

For the month of January 2022, the air temperatures were not measured or documented on one resident home area as follows: All shifts for one day; the morning for 2 days; the afternoon and evening for 11 days, and the evening for 2 days.

For the month of January 2022, the air temperatures were not measured or documented on another resident home area as follows: the morning on three days, the afternoon and evening for 3 days, and the evening for 2 days.

The maintenance staff indicated the housekeepers may have been away on some of the dates where no temperature was recorded.

The Environmental Services Supervisor indicated that the housekeepers were to measure and record the temperatures at the required times. They were away in January 2022, and was unsure why air temperatures were not measured and recorded.

When the air temperature logs were not completed as required, there was a risk that actions would not be taken in a timely manner to address the temperature in the room for residents' comfort.

[Sources: Record review of home's air temperature logs for January 2022, Maintenance Care status task list history; Observations in residents' rooms; Interviews with the resident, Maintenance Staff, Environmental Services Supervisor, Executive Director (ED), and other staff.] [s. 21. (3)]

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 temperature required to be measured under subsection is documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that the heating system in one resident’s room was in good state of repair, and was inspected at least every six months by a certified individual, and that documentation was kept of the inspection.

A resident indicated that they felt cold in their room, especially during the night. Their baseboard heater had been broken since last winter. They indicated they had reported their concerns to staff, but no one had come to repair the heater.

The baseboard heater in the resident’s room showed that it was not turned on, and the thermostat was set at 15 degrees C. The maintenance staff acknowledged that the baseboard heater in the resident’s room wasn't working, and they had not been aware of the issue.

There was no record that the resident had reported a concern that their heater was not working over the past year.

The maintenance staff indicated they checked the baseboard heaters once every year, but did not document these checks.

The Environmental Services Supervisor and Executive Director acknowledged that residents’ baseboard heaters should be checked and cleaned every six months, with proper documentation of the check.

When the procedure for the heating system was not implemented, there was a risk that disrepair would not be identified, and residents would be cold and uncomfortable in their room.

[Sources: Record review of home’s air temperature logs for January 2022, Maintenance Care status task list history, Resident’s progress notes; Observations in residents’ rooms; Interviews with the resident, Maintenance Staff, Environmental Services Supervisor, ED, and other staff.] [s. 90. (2) (c)]

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 procedures are developed and implemented to ensure that heating systems are cleaned and in good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents #005 and #006 in accordance with the directions for use specified by the prescriber.

A) Resident #005 was administered 90ml of their Oral Nutritional Supplement (ONS) instead of the ordered amount of 235 ml.

The RD ordered one bottle (235 ml) of the ONS at an identified frequency, to be administered to the resident. This order was transcribed into the resident's electronic-medication administration record (e-MAR) for administration by the nurse.

The resident was at high nutritional risk with a history of significant weight loss.

Failure of staff to provide resident #005 with the ordered amount of ONS placed them at an increased risk of inadequate nutritional intake.

The DOC acknowledged that the prescriber's order was not followed and staff should be administering the correct amount to the resident.

B) Resident #006 was administered 90 ml of an ONS instead of the prescribed 150 ml.

The nurse signed resident #006's e-MAR indicating they administered 150 ml of the ONS instead of the 90 ml that was administered.

The RD ordered 150 ml of the ONS to be administered to resident #006 three times a day due to poor nutritional intake and significant weight loss. The order was transcribed onto the resident's e-MAR for administration by the nurse.

Resident #006 was at high nutritional risk related to significant weight loss.

The RPN acknowledged that on that day, they had signed the e-MAR for the administration of 150 ml of the ONS but had only administered 90 ml.

Failure of staff to provide resident #006 with the prescribed amount of ONS put the resident at risk of poor intake and further weight loss.

[Sources: A) Observation of resident #005's medication pass, review of resident #005's clinical records, RD's order, interviews with RPN, RD, and DOC.

Sources: B) Observation of resident #006's medication pass, review of resident #006's clinical records, RD's order, interviews with RPN, RD, DOC, and other staff.] [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 9th day of March, 2022

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

Original report signed by the inspector.