Original Public Report

Report Issue Date: April 12, 2023	
Inspection Number: 2023-1212-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: Humber Valley Terrace Operating Inc.	
Long Term Care Home and City: Humber Valley Terrace, Etobicoke	
Lead Inspector Noreen Frederick (704758)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 22, 23, 24, 27, 28, 29, 30, 31, 2023

The following intake(s) were inspected:

- Intake: #00011302 - [CI: 2716-000020-22] Improper care resulting in an injury
- Intake: #00021715 - [CI: 2716-000001-23] Fall resulting in an injury
- Intake: #00021744 – complaint related to Fall resulting in an injury

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

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

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 (10) (b)

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

Rationale and Summary
The resident's bed was to be kept at the lowest level and in locked position when occupied as a fall prevention intervention. It was observed that the resident's bed was in a high position. Personal Support Workers (PSW) indicated that the resident preferred their bed in high position. Registered Nurse (RN) acknowledged that the resident's bed should be in the lowest position as indicated in the care plan. The plan of care was revised to include resident's preference related to bed height.

Sources: Resident's care plan; interview with PSW, and RN.

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Date Remedy Implemented: March 24, 2023.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)

The licensee has failed to ensure that care set out in the plan of care was based on a resident's preferences.

Rationale and Summary
A resident had a personal article which they liked to be applied to their assistive device prior to use. PSW stated that the resident always wanted this article on their assistive device. Registered Practical Nurse (RPN) and RN acknowledged that resident's care plan did not include this preference. Director of Care (DOC) stated that staff were expected to revise care plan based on resident's preference.

Failing to ensure that resident's care plan was based on their preference, placed resident at risk of not having their needs met.

Sources: The resident's care plan, and interviews with PSW, RPN, RN and DOC .

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WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The licensee has failed to ensure that the staff collaborated with each other in the implementation of the plan of care for a resident related to pain medication.

Rationale and Summary:
The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care (MLTC) related to improper transfer which resulted in a significant change in a resident's status.

The resident exhibited pain during care. Electronic Medication Records (EMAR) revealed that as needed (PRN) pain medication was not administered to the resident prior to care. PSW #112, #113, #118, and #119 stated that the resident exhibited sign and symptoms of pain during care however, they did not collaborate with the registered staff to administer PRN pain medication prior to care. RPN #111, #116, and RN #114 stated that the PSWs did not report resident's pain, therefore they did not administered PRN pain medication.

DOC acknowledged that the PSWs and Registered staff were expected to collaborate with each other to ensure intervention of PRN pain medication was implemented to manage the resident's pain.

Staff failure to collaborate with each other put the resident at risk of not receiving effective treatment to mange their pain.

Sources: The resident's clinical records, and interviews with PSW #112, #113, #118, #119, RPN #111, #115, #116, RN #114 and DOC.

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WRITTEN NOTIFICATION: PASDs that limit or inhibit movement

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 36 (3)
The licensee has failed to ensure that a Personal Assistance Service Device (PASD) in use by a resident was included in the resident's plan of care.

Rationale and Summary
A resident's plan of care revealed that there was no indication of PASD use when using their assistive device. PSW #100, #104, RPN # 101, RN #102, and #106 stated that the resident used PASD daily when using their assistive device. DOC acknowledged that staff were expected to only use the PASD if it is included in the plan of care.

Failure to ensure that the resident's PASD was plan of their care, placed the resident at risk for potential injury.

Sources: The resident's clinical records, and interviews with PSW #100, #104, RPN #101, RN #102, #106 and DOC.

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WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

Rationale and Summary
The resident required the use of an assistive device for transfers. PSW #109, and #110 stated that on an identified date, they used an assistive device which was not part of the resident's plan of care when assisting the resident. The resident was found with an injury a few days later. The home's investigation concluded that resident's injury was likely caused by the use of an incorrect assistive device .

DOC acknowledged that unsafe transferring and positioning techniques were used by PSW #101 and PSW #110 while assisting the resident.

As a result of improper transferring techniques, a resident was placed at risk of injury.

Sources: The resident's clinical records, home's investigation notes, and interviews with PSW #109, #110, and DOC .

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WRITTEN NOTIFICATION: Required Programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.

The licensee has failed to ensure that the pain management program to identify and manage pain was implemented for a resident.

In accordance with O. Reg 246/22, 11 (1) (b), the licensee is required to ensure a pain management program to identify and manage pain is implemented and is complied with.

Specifically, the home did not comply with their policy CARE 8-O10.02 "Pain Assessment and Management" reviewed date March 31, 2022.

Rationale and Summary
On an identified date, a resident was found with an injury and was in pain. The resident continued to experience pain daily with care as acknowledged by PSW #112, #113, #118, and #119. According to the home's pain assessment and management policy, "The Unregulated Care Provider (UPC) will document pain observed or verbalized". The PSWs documented that the resident did not voice or show signs of pain. DOC acknowledged that the home's policy was not complied and the PSWs were expected to document the resident's pain.

Failure to document regarding the resident's pain, increased the risk of the resident not receiving the interventions to manage their pain.

Sources: The resident's clinical records, policy CARE 8-O10.02 "Pain Assessment and Management" reviewed date March 31, 2022, and interviews with PSW #112, #113, #118, #119, and DOC.

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

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WRITTEN NOTIFICATION: Falls prevention and management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident fell, the resident was assessed.

In accordance with O. Reg 246/22, 11 (1) (b), the Long-Term Care Homes (LTCH) ’s Fall Prevention and Injury Reduction policy which was included in the LTCH’s Falls Prevention and Management program was complied with when resident #001 fell and sustained a right femur fracture.

Rationale and Summary
A resident had an unwitnessed fall with injury. The home’s policy CARE 8-O10.05 “Fall Prevention and Injury Reduction” reviewed date March 31, 2022, stated “A Post-Fall Assessment is completed by the Nurse immediately following the fall". RN #102, #106 and RPN #101, and #103 were all present during the fall incident. Each one of them stated that they did not complete a post fall assessment. DOC acknowledged that registered staff were expected to complete a post fall assessment when the resident fell.

Failing to comply with the LTCH’s policy put the resident at risk for delayed identification of changes to the resident’s health status following a fall.

Sources: The resident’s clinical records, LTCH’s policy CARE 8-O10.05 “Fall Prevention and Injury Reduction” reviewed date March 31, and interviews with RN #102, #106, RPN#101, #103 and DOC .

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