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: September 13, 2023	
Inspection Number: 2023-1212-0003	
Inspection Type: Critical Incident	
Licensee: Humber Valley Terrace Operating Inc.	
Long Term Care Home and City: Humber Valley Terrace, Etobicoke	
Lead Inspector Michael Chan (000708)	**Inspector Digital Signature** Michael K Chan Digitally signed by Michael K Chan Date: 2023.09.14 10:39:20 -04'00'
Additional Inspector(s) Yannis Wong (000707)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 7, 8, 11, 2023

The following intake(s) were inspected in the Critical Incident System (CIS) Inspection:

- Intake: #00090033 - 2716-000005-23 - related to a fall resulting in injury
- Intake: #00093829 - 2716-000006-23 - related to a fall resulting in injury

Saran Daniel-Dodd, Training Specialist (116) was also present during the inspection.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Maintenance services

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (b)

The licensee has failed to ensure that all devices in the home are kept in good repair.

Specifically, a resident's fall prevention device was damaged.

Rationale and Summary
A resident sustained a fall for which they were sent to the hospital. The resident had a fall prevention device in place. A Personal Support Worker (PSW) and Registered Nurse (RN) stated the device did not function as intended at the time of the resident's fall. During the home's investigation, the Director of Care (DOC) identified the resident's fall prevention device was broken.

The DOC acknowledged there was no related policy to direct staff to conduct a check to ensure the device was in working order. PSW could not recall if the device was utilized on the day of the incident and was unable to confirm whether they checked if it was working. The DOC acknowledged the device was not maintained in good repair.

Failure to ensure the resident's fall prevention device was in good repair resulted in increased risk for injury due to a delay in responding to their fall.

Sources: Interviews with staff and DOC; resident's clinical records; home's investigation notes

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WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

The licensee has failed to ensure that the Director is informed of an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the

resident's health condition, no later than one business day after the occurrence of the incident.

Rationale and Summary
A resident sustained a fall for which they were transferred to the hospital on the same day. The home was aware the resident had an injury resulting in significant change to their health condition on the following day. The Ministry of Long-Term Care (MLTC) was not informed until the home submitted a Critical Incident System (CIS) three business days after the incident.

The DOC confirmed the critical incident was reported late and should have been submitted within one business day.

Failure to report the incident to the Ministry within one business day could lead to a delayed response from the Ministry.

Sources: CIS report; resident's clinical records; interview with DOC

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