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
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Original Public Report

Report Issue Date: November 21, 2023

Inspection Number: 2023-1709-0001

Inspection Type:
Complaint
Critical Incident
Post-Occupancy

Licensee: Humber Meadows Long-Term Care Home

Long Term Care Home and City: Humber Meadows Long-Term Care Home, Toronto

Lead Inspector	**Inspector Digital Signature**
Nital Sheth (500)	Nital Sheth Digitally signed by Nital Sheth Date: 2023.11.24 08:30:26 -05'00'

Additional Inspector(s)
Joy Ieraci (665)
Kehinde Sangill (741670)
Adelfa Robles (723)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 5-6, 10, 12-13, 16-20, 23, off-site November 2-3, 6, 2023.

The following intake(s) were inspected:

- Intakes: #00093719, #00093905, #00095655, and #00098076 - were related to fall incidents resulting in injury
- Intakes: #00095285, and #00098396 - were related to outbreaks of a disease of public health significance
- Intake: #00097655 - was related to alleged neglect
- Intake: #00098008 - was a complaint related to medication management, continence care and bowel management, responsive behaviours, and plan of care
- Intake: #00098721- was a complaint related to falls management
- Intake: #00098556 - Post Occupancy Inspection

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

Continence Care
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management
Admission, Absences and Discharge

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)
O. Reg. 246/22, s. 138 (1) (a) (i)

The licensee has failed to ensure that drugs were stored in an area that was used exclusively for drugs and drug-related supplies.

Rationale and Summary

Two containers of a topical medication were left unattended. PSW #130 stated that they left the containers and went to attend to another resident. Registered Practical Nurse (RPN) #131 verified that they asked the PSW to take the medication to the resident's room and acknowledged the medication should have been stored in a locked medication room or cart until administration time.

The medication was immediately removed and stored in a secure location.

The Resident Home Area (RHA) manager #108 acknowledged that medications should not have been left unattended and should have been stored in a secured locked area.

Sources: Observation (October 18, 2023); the home's Medication Administration Policy (VIII-E-13.00. reviewed October 17, 2023); interviews with PSW #130, RPN #131, and RHA manager #108. [741670]

Date Remedy Implemented: **October 18, 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 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to two residents as specified in the plan.

Rationale and Summary

(1). A resident was identified at risk for falls at the time of admission. The resident had a fall three days later. An identified intervention was agreed upon with the resident's substitute decision-maker (SDM), however, it was not implemented until three days later.

Interviews with RHA Manager #108, Falls Prevention and Management program lead #112, and Assistant Director of Care (ADOC) confirmed the identified intervention should have provided to the resident when consent was obtained from the SDM.

Failure to implement the identified intervention to the resident increased their risk for injury related to a fall.

Sources: Review of resident's plan of care, progress notes, policy on Falls Prevention and Management (VII-G-30.10, reviewed, May 4, 2023), interviews with RHA Manager #108, Falls Prevention and Management Program lead #112 and ADOC. [500]

(2). A resident was admitted with a history of a specified health condition and prescribed a protocol. According to the protocol in place, registered staff were to implement interventions on 20 identified days over a two-month period. The interventions were not provided to the

resident as per the protocol. The resident was subsequently sent to hospital the following month and treated for complications related to their health condition.

RPN #134 and Director of Care (DOC) acknowledged that the protocol should have been implemented as per the order.

Staff's failure to follow resident's plan of care put them at risk of complications related to medical condition.

Sources: Resident clinical records; interview with RPN #134, DOC and other staff. [741670]

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) (a)

The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident collaborated with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

Rationale and Summary

The resident had a significant change in a specific laboratory (lab) value in a one month period. RPN #138 notified Physician #137 about the change.

Physician #137 confirmed that the significant change in the lab value required an immediate assessment. RPN #138 verified that they did not receive communication from physician #137, and it was endorsed to the next shift. There was no follow-up from the staff to physician #137, related to the resident's lab value, until the physician assessed the resident four days later. On the same day, the resident's condition changed, and they were transferred to the hospital.

Interview with ADOC confirmed that staff should have followed up with the physician to assess the resident for their significant change in their lab report.

Failure to collaborate with the physician in a timely manner placed the resident at risk of potential harm to their health condition.

Sources: CIS, resident's clinical record review, progress notes, interviews with RPN #138, physician #137, and ADOC. [500]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to document the provision of care related to responsive behaviour for one resident.

Rationale and Summary

The resident was noted with responsive behaviour and an intervention of a monitoring protocol was initiated.

The monitoring record indicated missing documentation for two identified days.

The DOC verified that staff were required to complete all documentation related to monitoring for the resident.

Failure to complete monitoring documentation may impact the resident's responsive behaviour management.

Sources: Resident's progress note and documentation record, and interview with DOC. [741670]

WRITTEN NOTIFICATION: CARE PLAN

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (2) (1)

The licensee has failed to ensure that a resident's 24-hour care plan identified the resident at risk of falling and interventions to mitigate those risks.

Rationale and Summary

The resident had a fall which resulted in injury. The resident had two previous falls.

The resident was identified at risk for falls at the time of admission. The resident's care plan for falls prevention was not initiated until the resident's third fall which resulted in injury.

The home's policy indicated that a care plan must be developed within 24 hours for each resident moving into the home. The initial 24-hour care plan must include risks the resident may pose to themselves, including falling and interventions to mitigate the risk.

Interviews with RPN #119, RHA Manager #108, Falls Prevention and Management program lead #112 and ADOC confirmed that the resident's care plan for falls prevention should have been developed at the time of their admission.

Failure of the home to initiate a fall prevention care plan for the resident placed them at risk of injury.

Sources: Resident's plan of care, Plan of Care and Care Plan Definitions policy (VII-C-10.90 (e), reviewed, April 25, 2023), interviews with RPN #119, RHA Manager #108, Falls Prevention and Management program lead #112 and ADOC. [500]

WRITTEN NOTIFICATION: SAFE AND SECURE

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5

The licensee has failed to ensure that the home was a safe and secure environment for a resident.

Rationale and Summary

The resident had a fall when they used a specified chair. The resident was identified at risk for falls at the time of admission.

Interview with RPN #119, RHA manager #108 and Falls Prevention and Management program lead #112 confirmed that the resident should have not been provided the specified chair with due to risk of falls.

Staff providing the specified chair to the resident caused them to fall and increased their risk of injury.

Sources: Progress notes, resident's plan of care, interviews with RPN #119, RHA Manager #108 and Falls Prevention and Management program lead #112. [500]

WRITTEN NOTIFICATION: DOORS

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1.

The licensee has failed to ensure that the doors that residents do not have access to were kept closed and locked.

Rationale and Summary

During initial tour completed on October 5, 2023, the inspector identified the following doors not locked:

- Second North spa room door #2021
- Four North tub room did not latch properly and was unlocked
- Main floor beauty salon
- Janitor room door #6243

Interviews with RN #113, RN #114, PSW #115, and Manager of Facilities confirmed that the above mentioned doors were required to be locked when not in use.

The doors that residents do not have access to being unlocked increased the risk for unsupervised access of residents to identified areas.

Sources: Observation (October 5, 2023), interviews with RN #113, RN #114, PSW #115, and Manager of Facilities. [500]

WRITTEN NOTIFICATION: COMPLAINT PROCEDURE

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee has failed to ensure that a written complaint related one resident's care was immediately forwarded to the Director.

Rationale and Summary

The home received a complaint via email. In the email, the complainant requested that the matter be dealt with as a formal complaint in accordance with the home's complaint procedure.

The home's complaints policy directed the Executive Director (ED) or designate to immediately forward all written complaints to the Director.

The ED acknowledged that the written complaint was not forwarded to the Director.

Sources: Complaint letter, Complaint Management Policy (XXIII-E-10.00, original policy date, April 17, 2023); and interview with the ED. [741670]

WRITTEN NOTIFICATION: RESIDENT INFORMATION PACKAGE

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 84 (2) (p)

The licensee has failed to ensure that the contents of the information package for residents included information about the Family Council (FC).

Rationale and Summary

The home's new admission's Resident Information Package did not include information related to Family Council (FC).

The inspector observed that the information package presented to a resident's family members did not include information about FC.

The Director of Social Services (DSS) confirmed that the information about FC was not included in the Resident Information Package presented to the resident's family members.

Failure of the home to provide information on FC upon admission could lead to a violation of residents' rights, in particular transparency and accountability.

Sources: Resident admission observation, Humber Meadows Long Term Care Home's (LTC) Resident Information Package and interview with DSS. [723]

WRITTEN NOTIFICATION: RESIDENT INFORMATION PACKAGE

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 264 (2) 9.

The licensee has failed to ensure that the contents of the information package for residents included information about the current version of the home's visitors policy.

Rationale and Summary

The home's Resident Information Package for newly admitted residents did not include information about the home's visitors policy. The home's policy indicated that a copy of the visitors policy must be included in the Resident Information Package.

During a resident's admission, the Information Package presented to the family members did not include information about the home's visitors policy.

The DSS confirmed that the information on visitors policy was not included in the Resident Information Package presented to the resident's family members upon admission.

Failure of the home to include information about the visitors policy compromised the resident's right to transparency and accountability.

Sources: Resident admission observation, Humber Meadows LTC's Resident Information Package, the home's Visitors Policy (XIV-10.10, Current Version, reviewed May 12, 2023), and interview with DSS. [723]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL (IPAC)

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The Licensee has failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, when the required personal protective equipment (PPE) was not followed by staff in the COVID-19 outbreak RHA.

Rationale and Summary

(1). In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, and the Ministry of Health COVID-19 Guidance for Public Health Units: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings Version 11, updated June 26, 2023, the required PPE for providing direct care to a resident with confirmed COVID-19 were a fit-tested, seal-checked N95 respirator (or approved equivalent), appropriate eye protection (goggles, face shield, or safety glasses with side protection), gown and gloves.

PSW #124 provided direct care to a resident, who was a confirmed COVID-19 case, without wearing an isolation gown and eye protection on three occasions within a 15-minute period. The PSW confirmed that the resident was on droplet/contact precaution for COVID-19 and did not wear the appropriate PPE of the gown and eye protection when they provided direct care to the resident.

The Infection Prevention and Control (IPAC) lead indicated that other staff and residents were at risk of COVID-19 infection when the appropriate PPE was not worn by PSW #124.

There was a risk of COVID-19 transmission to residents and staff in the resident home area (RHA) when PSW #124 did not wear the required PPE when direct care was provided to the resident.

Sources: Observations, review of Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, Ministry of Health COVID-19 Guidance for Public Health Units: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings Version 11, updated June 26, 2023, and resident's progress notes, and interviews with PSW #124, IPAC Lead and other staff. [665]

(2). Toronto Public Health (TPH) declared a specific home area in a confirmed COVID-19 outbreak. TPH provided guidance to the home indicating that eye protection was to be worn by staff when interacting within two metres of residents in the outbreak area.

PSW staff provided direct care to residents without wearing the required eye protection. Additionally, a registered staff administered medications to residents in the dining room without wearing eye protection.

ADOC confirmed they were aware of the recommendation from TPH and staff in the outbreak area did not wear the required eye protection when they interacted with residents.

There was a risk of further COVID-19 transmission to residents and staff when staff did not wear the required PPE in the outbreak area in accordance with the Ministry of Health COVID-19 guidance document.

Sources: Observations in the identified RHA, review of Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, Ministry of Health COVID-19 Guidance for Public Health Units: Long-Term Care Homes, Retirement Homes, and Other

Congregate Living Settings Version 11, updated June 26, 2023, and TPH PPE recommendations, dated October 2, 2023, and interviews with ADOC and other staff. [665]

(3). Staff members, private care givers, and visitors did not wear eye protection in RHA affected with the COVID-19 outbreak.

Interview with IPAC lead confirmed that staff were required to wear eye protection only for direct care in the RHA with the COVID-19 outbreak which is not in accordance with Ministry of Health COVID-19 Guidance for Public Health Units: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings Version 11, updated June 26, 2023.

There was a risk of further COVID-19 transmission to residents, staff, and visitors when they did not wear the required eye protection in the outbreak area.

Sources: Observations in specified RHA, review of Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, Ministry of Health COVID-19 Guidance for Public Health Units: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings Version 11, updated June 26, 2023, and interviews with IPAC lead and other staff. [500]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL (IPAC)

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure the implementation of a standard issued by the Director with respect to infection prevention and control (IPAC).

(1). The home has failed to ensure that there was in place a hand hygiene program in accordance with the "IPAC Standard for Long-Term Care Homes April 2022". Specifically, support for residents to perform hand hygiene prior to receiving snacks as required by Additional Requirement 10.4 (h) under the IPAC Standard.

Rationale and Summary

PSWs #120 and #121 provided residents with their snack in the resident lounge. The PSWs did not support residents who were able to feed themselves with hand hygiene prior to receipt of their snack.

Both PSWs acknowledged that they did not support the residents with hand hygiene prior to providing their snacks.

Failure to provide hand hygiene to residents increased the risk of infection transmission to other residents and staff.

Sources: Snack observation, review of IPAC Standard for Long-Term Care Homes April 2022, and interviews with PSWs #120 and #121 and other staff. [665]

(2). The home has failed to ensure that Routine Practices were in accordance with the "IPAC Standard for Long-Term Care Homes April 2022". Specifically, hand hygiene as required by Additional Requirement 9.1 (b) under the IPAC standard.

Rationale and Summary

(A). PSWs #120 and #121 provided residents with their nourishment. The PSWs did not perform hand hygiene after each resident contact, after handling dirty dishes and before handling and preparing beverages.

Both PSWs acknowledged that they did not perform hand hygiene when they provided nourishment to the residents.

Residents were at risk of infection when PSWs #120 and #121 did not perform hand hygiene.

Sources: Snack observation, review of IPAC Standard for Long-Term Care Homes April 2022, and interviews with PSWs #120 and #121 and other staff. [665]

(B). A specified RHA was in a confirmed COVID-19 outbreak. Housekeeper #122 emptied the garbage in four resident rooms, without performing hand hygiene before initial and after resident/resident environment contact. The housekeeper did not change their gloves when they emptied the garbage and had touched the residents' entrance doors and washroom door handles with the same gloves.

The home's policy directed housekeepers to perform hand hygiene between handling individual residents' garbage and after handling waste.

The IPAC lead acknowledged that the housekeeper was supposed to perform hand hygiene to prevent infection transmission to residents and staff.

Residents and staff were at risk of infection when Housekeeper #122 did not perform hand hygiene before initial and after resident/resident environment contact.

Sources: Observations, review of home's policy, Aramark Senior Living Hand Hygiene, last reviewed June 30, 2021, IPAC Standard for Long-Term Care Homes April 2022, and interviews with the IPAC lead and other staff. [665]

(3). The home has failed to ensure that Additional Precautions were in accordance with the "IPAC Standard for Long-Term Care Homes April 2022". Specifically, PPE requirements including appropriate selection application, removal and disposal as required by Additional Requirement 9.1 (f) under the IPAC standard.

Rationale and Summary

The home's specified RHA was in a confirmed COVID-19 outbreak. PSWs #123 and #124 provided direct care to a resident, who was a confirmed case and was on precautions.

PSW #124 did not remove their gloves and both PSWs did not remove and change their N95 masks after they provided care to the resident.

Both PSWs confirmed that they were to remove their N95 masks outside the resident's door and apply a new one. PSW #124 indicated they were supposed to remove their gloves after care was provided but did not.

The IPAC lead acknowledged that the PSWs did not appropriately use PPE after they provided care to the resident, to reduce the risk of infection transmission to other residents and staff.

Failure of PSWs #123 and #124 to appropriately remove and apply PPE in accordance with additional precautions put residents and staff at risk of infection transmission.

Sources: Resident care observations, review of IPAC Standard for Long-Term Care Homes April 2022, and resident's progress notes, and interviews with PSWs #123 and #124 and IPAC Lead. [665]

WRITTEN NOTIFICATION: REPORTING REQURIEMENT

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

The licensee has failed to ensure that the Director was immediately informed of an outbreak of a disease of public health significance.

Rationale and Summary

Toronto Public Health declared a confirmed respiratory outbreak in the home on August 22, 2023. The home notified the Director the following day.

The IPAC lead acknowledged that the Director was not notified immediately of the respiratory outbreak.

There was no risk to the residents when the Director was not notified immediately of the respiratory outbreak.

Sources: CIS report and interview with the IPAC lead. [665]

WRITTEN NOTIFICATION: HAZARDOUS SUBSTANCES

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97

The licensee failed to ensure that all hazardous substances in the home were kept inaccessible to residents at all times.

Rationale and Summary

The inspector observed a 4.5 litres (L) jug of liquid detergent, approximately 1/4 full left unattended on top of a washer inside the unlocked laundry room. There were six residents in the TV lounge near the laundry room.

PSW #127 and RHA Manager #108 verified that the liquid detergent should have not been left unattended.

There was a risk to residents when the laundry detergent was left unattended in the resident home area.

Sources: Observation, interviews with PSW #127 and RHA Manager #108. [723]

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

(1). A physician order written for a medication should be given twice daily when needed. The resident's Electronic Medication Administration Record (eMAR) showed that the medication was given to the resident three times on an identified day.

RPN #131 acknowledged that they administered an additional dose of the medication in their shift.

Staff failure to follow the resident's plan of care related to medication administration put them at risk of adverse effects.

Sources: Review of resident's clinical records, interview with RPN #131 and other staff. [741670]

(2). The resident's eMAR indicated a physician order for a medication once a day at a specified time. The medication was not administered to the resident at the specified time on two days.

RPNs #119 and #131 verified that the physician order for the medication required that it be administered at the specified time. Both RPNs indicated that the medication was not administered at the specified time.

The medication administration policy directs registered staff to administer a medication as close to the scheduled time as possible and within one hour before or after the designated time.

Failure to administer resident medications at the time specified by the prescriber increased the risk of medications not providing the desired effect.

Sources: Observation of medication administration; review of resident's clinical records, Home's Medication Administration Policy (VIII-E-13.00, reviewed, October 17, 2023); interviews with RPN #119, #131 and other staff. [741670]

WRITTEN NOTIFICATION: MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)

The licensee has failed to ensure that a medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

Rationale and Summary

The resident was administered three doses of a medication as needed (PRN). The physician order for PRN medication was twice daily. The home was unable to provide a medication incident report related to the medication incident.

The home's medication administration policy directs staff to document medication related events, including an error in administering a medication, on medication error forms as well as tracking and analyzing the error as per quality schedule and plan.

The DOC noted that this would be considered a medication incident. They acknowledged that a medication incident report should have been completed related to the above mentioned incident. The DOC confirmed they could not find a medication incident report for the medication error.

Failure to document medication incidents may impact the home's ability to accurately identify trends and implement appropriate corrective actions.

Sources: Resident clinical records, the home's Medication Administration Policy (VIII-E-13.00, reviewed, October 17, 2023); interviews with RPN #131, and DOC. [741670]