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: January 26, 2024	
Inspection Number: 2023-1709-0002	
Inspection Type: Critical Incident	
Licensee: Humber Meadows Long-Term Care Home	
Long Term Care Home and City: Humber Meadows Long-Term Care Home, Toronto	
Lead Inspector Reji Sivamangalam (739633)	**Inspector Digital Signature** Reji K Sivamangalam Digitally signed by Reji K Sivamangalam Date: 2024.02.09 13:51:47 -05'00'
Additional Inspector(s) Dorothy Afriyie (000709)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 14, 18 - 22, 28 - 29, 2023 and January 2 and 3, 2024

The following intake(s) were inspected:
- Intake: #00095060 [Critical Incident System (CIS) #3065-000008-23] related to resident-to-resident abuse.
- Intake: #00097123 (CIS #3065-000013-23) related to improper care
- Intake: #00099547 (CIS #3065-000024-23) related to alleged abuse of a resident

The following intake (s) were completed:

- Intakes: #00097566 (CIS #3065-000014-23), #00098143 (CIS #3065-000019-23), #00098173 (CIS #3065-000020-23), #00098553 (CIS #3065-000022-23), #00099971 (CIS #3065-000025-23), #00100005 (CIS #3065-000026-23), #00101890 (CIS #3065-000036-23) and #00101986 (CIS #3065-000037-23) were related to fall prevention and management.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident.

The licensee failed to ensure that the care set out in a resident's plan of care provided clear direction to the staff.

Rationale and Summary

The home submitted a CIS report related to a resident's injury during care. The home's internal investigation notes indicated that staff were aware that the resident exhibited a specific behaviour during the care.

Staff members confirmed that the resident exhibited specific behaviours during their care and indicated that one staff member needed to assist the resident and the other staff operated a device due to the behaviour. Physiotherapist Assistant (PTA) confirmed that the resident at times exhibited the behaviour during a program.

Review of the resident's care plan did not include interventions directing staff on how to manage their behaviour.

The staff members acknowledged the plan of care did not provide a clear direction to staff related to managing the resident's behaviour.

There was a risk of injury to the resident when staff who provided direct care to the resident did not have clear directions on how to manage their behaviour.

Sources: CIS report, resident's plan of care, and interviews with staff members.

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WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
Integration of assessments, care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

The licensee has failed to ensure that staff members collaborated with each other in completing an assessment for a resident.

Rationale and Summary

A resident was exhibiting responsive behaviours and had an incident. A referral for a specific assessment was initiated, following the incident, but no assessment was completed in response to the referral.

The staff members stated they did not assess the resident but acknowledged that they were expected to follow up with the referral and assess the resident.

The Director of Care (DOC) acknowledged that staff did not collaborate with each other in responding to the referral for the resident; hence, an assessment was not completed.

Failure to complete resident's assessment put the resident at risk of their health condition not being appropriately managed.

Sources: Resident's clinical records, interviews with staff members.

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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 (9) 1.
Plan of care
Documentation
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to document the provision of care related to the monitoring of a resident.

Rationale and Summary

A resident's plan of care indicated every shift monitoring and every shift progress notes to be completed in order to monitor a specific responsive behaviour.

Record review of the resident's documentation indicated the resident continued to display the behaviours. However, documentation was missing on multiple dates during a specific period of time.

The staff members acknowledged that staff were required to document on the resident's behaviours every shift.

Failure to document the responsive behaviours may impact the ability to evaluate the effectiveness of behavioural management.

Sources: The resident's record review, interview with staff members.

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WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident had occurred, immediately reported the suspicion and information upon which it was based to the Director.

Rationale and Summary

The home submitted a CI report related to an allegation of an abuse towards a resident. The CI was submitted on a specific date with an earlier occurrence date.

The home's policy stated that all team members and families with reasonable grounds to suspect abuse of a resident has occurred or may occur are required to report to the provincial health authorities and the Executive Director or designate in charge of the community, per timelines.

The staff members acknowledged that the incident was reported to them. However, they did not report the allegation of abuse immediately as per the home's policy.

The staff member stated that they sent an email to the Resident Home Area Manager (RHA) and the DOC about the allegation of abuse and the RHA confirmed the receipt of the email.

DOC acknowledged that the incident should have been reported immediately to the Director.

The home's failure to report to the Director immediately after becoming aware of the allegation of abuse of the resident, did not place the resident at risk.

Sources: The home's policy and interview with staff members.

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WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (2)

Falls prevention and management

s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Rationale and Summary

The home's policy required an assessment to be completed post-fall. The assessment should include a physical assessment, and to ensure the resident was not moved before the completion of a preliminary assessment.

A record review showed that no post-fall assessment was completed after the resident's fall.

Staff members confirmed that they did not complete a post-fall assessment when the resident fell and acknowledged that the resident was at risk for unidentified injury when the post fall assessment was not completed.

Failure to assess the resident after a fall could increase the risk of not identifying an injury in a timely manner and therefore not providing the appropriate care.

Sources: Resident's record review. interviews with staff members and home's policy.

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WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (2) (b)
Responsive behaviours
s. 58 (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(b) based on the assessed needs of residents with responsive behaviours.

The licensee has failed to ensure that staff completed behavioural assessments for a resident when they exhibited responsive behaviours.

Rationale and Summary

A resident had a history of responsive behaviours before their admission to the home and had exhibited specific behaviours since admission.

The home's policy directed staff to complete specific behavioural assessments based on the resident's needs when a resident exhibited responsive behaviours.

Staff members stated that behavioural assessments should be completed for residents with known responsive behaviours on admission and when they exhibit responsive behaviours as per policy and acknowledged that no behavioural assessments were completed for the resident.

There was a risk of not identifying the resident's needs and behavioural triggers to develop appropriate techniques and interventions for managing their responsive behaviours when required assessments were not completed.

Sources: Resident's clinical records, the home's policy and interviews with staff members.

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WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #007 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 that Behavioural Support Ontario-Dementia Observation System (BSO-DOS) were completed and analyzed for a resident's responsive behaviours.

Rationale and Summary

(i) DOS monitoring was initiated for a resident for a specific period after a physical altercation with another resident. A review of BSO-DOS documentation showed missing information for multiple days, and after the observation periods, the analysis of the observation findings was not completed.

Staff members acknowledged that the DOS was not completed as required and the staff were expected to document BSO-DOS observation on specific intervals and an analysis should have been completed after the observation period ended.

Failure to document BSO-DOS and complete the analysis assessment placed the resident at risk for not receiving appropriate care as a result of unidentified behavioural triggers.

Sources: Resident's clinical records, CIS report, and interviews with the staff members.

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The licensee has failed to ensure that BSO-DOS were completed and analyzed for a resident's responsive behaviours.

Rationale and Summary

(ii) DOS monitoring was initiated for a resident for a specific period related to their responsive behaviours. A review of BSO-DOS documentation showed missing information for multiple days, and after the observation periods ended, the analysis of the observation findings were not completed.

Staff members acknowledged that the DOS monitoring was not completed as required and stated that staff were expected to document BSO-DOS observation on specified intervals and an analysis should have been completed after the observation period ended.

Failure to document BSO-DOS and complete the analysis assessment placed the resident at risk for not receiving appropriate care as a result of unidentified behavioural triggers.

Sources: Resident's clinical records and interviews with staff members.

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The licensee has failed to ensure that BSO-DOS were completed and analyzed for a resident's responsive behaviours.

Rationale and Summary

(iii) Specifically, when the resident demonstrated responsive behaviours, actions were not taken to document behaviours, the response to the needs of the resident including assessments, reassessments and interventions.

The home's policy indicated if a resident had a known history of responsive behaviour, a nurse to complete behavioural assessments based on the resident's needs.

A review of the resident's record showed none of the following assessments: Behavioral Assessment Tools (BAT), Depression Scale, Mini-Mental, Cohen-Mansfield Aggression Inventory, and PIECES. were completed even though the resident had a history of responsive behaviours.

During an interview with the BSO lead, they confirmed that the resident was discharged from the BSO portfolio without reassessment and the resident continued to exhibit responsive behaviours.

The DOC acknowledged the required behavioural assessments were not completed for the resident.

BSO-DOS data collection sheet was initiated for the resident for a specific period. However, the information from the sheet was not analyzed.

The DOS monitoring record indicated missing documentation on two instances during the period.

Failure to complete the behavioural assessments placed the resident at risk of not receiving appropriate care as a result of unidentified behavioural triggers.

Sources: Resident's clinical records, Interviews with staff members and the home's policy.

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WRITTEN NOTIFICATION: ALTERCATIONS AND OTHER INTERACTIONS

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59 (b) identifying and implementing interventions.

The licensee has failed to identify and implement interventions to minimize the risk of altercations and potentially harmful interactions among residents.

Rationale and Summary

A resident exhibited responsive behaviours since admission. Their responsive behaviours included specific behaviours that led to physical and verbal altercations with other residents.

Staff members stated that re-directing the resident was not always effective, and they tried different strategies to prevent altercations with little effect and, no interventions were included in the resident's plan of care to prevent altercations other than re-directing the resident and acknowledged that there should have been specific interventions trialed to assist staff in preventing these altercations.

The staff member confirmed that different strategies should have been identified and developed to prevent the resident from getting into altercations with other residents.

Failure to identify and implement strategies to reduce the risk of the resident getting into altercations with other residents placed the resident and others at risk for harm.

Sources: Residents' clinical records, the home's policy and interviews with the staff members.

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