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: February 16, 2024
Inspection Number: 2024-1709-0001
Inspection Type: Critical Incident (CI)
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**
Joy Ieraci (665)	Maria Joy Ieraci Digitally signed by Maria Joy Ieraci Date: 2024.02.20 10:03:35 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 6, 7, 8, 9, 13, 14, 2024

The following intake(s) were inspected:

- Intakes: #00100630 and #00101516 related to administration of drugs;
- Intake: #00105907 related to a disease outbreak and;
- Intake: #00106102 related to a fall.

The following intake(s) were completed in this inspection:

- Intakes: #00104019, #00104115 and #00105538 were related to falls and;
- Intakes: #00104101 and #00101052 were related to a disease outbreak.

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

Medication Management
Infection Prevention and Control
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 (9) 1.
Plan of care
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 home has failed to ensure that the provision of the care set out in the plan of care for a resident was documented.

Rationale and Summary

The resident had a medical order to manage a health condition. The provision of the medical order was not documented.

A registered nurse (RN) indicated they provided the medical order to the resident and should have documented the treatment provided.

There was no risk to the resident, however failure to document the treatment

provided may have affected the home's care and treatment of the resident's health condition.

Sources: Review of a resident's clinical records and interviews with an RN and other staff. [665]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary

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

Rationale and Summary

The home submitted a CI to the Ministry of Long-Term Care (MLTC) related to a fall a resident had which resulted in a transfer to hospital with injury.

The resident was assessed to be at risk of falls since admission. The resident had a history of falls and the plan of care did not have interventions to prevent and manage their falls since admission.

An RN indicated that it was the home's process to review and revise the plan of care

after each fall. They acknowledged they did not review and revise the plan of care to include fall interventions on one of the resident's falls.

The Director of Care (DOC) verified that the resident's plan of care did not have fall interventions to prevent and manage their falls since admission.

Failure to review and revise the resident's plan of care to prevent and manage falls, could have prevented or minimized the injury the resident sustained.

Sources: Review of CI report, a resident's clinical records and interviews with an RN, DOC and other staff. [665]

WRITTEN NOTIFICATION: MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health

The licensee has failed to ensure that every medication incident involving a resident, every use of glucagon, every incident of severe hypoglycemia involving a resident was documented.

Rationale and Summary

The resident received a medication to treat a health condition. The medication incident was not documented, which was verified by the DOC.

Failure to document the medication incident impacted the effectiveness of the home's analysis and evaluation of their medication incidents.

Sources: Review of a resident's clinical records and interview with the DOC. [665]

WRITTEN NOTIFICATION: MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (3) (a)
Medication incidents and adverse drug reactions
s. 147 (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents, incidents of severe hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon that have occurred in the home since the time of the last review in order to,
(i) reduce and prevent medication incidents and adverse drug reactions,
(ii) improve the use of glucagon and to improve the care and treatment of incidents of severe hypoglycemia and incidents of unresponsive hypoglycemia in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and
(iii) identify patterns of incidents of severe hypoglycemia and incidents of unresponsive hypoglycemia

The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents, incidents of severe hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon that have occurred in the home in order to reduce and prevent medication incidents and adverse drug reactions and improve the use of glucagon and to improve the care and treatment of incidents of severe hypoglycemia and incidents of unresponsive hypoglycemia.

Rationale and Summary

A medication incident report (MIR) was completed on a resident.

The DOC was unable to provide documentation of the home's quarterly reviews of all medication incidents. The DOC verified that the home had not conducted any quarterly reviews of their medication incidents, incidents of severe hypoglycemia and unresponsive hypoglycemia and every use of glucagon that occurred in the home.

Failure to conduct quarterly reviews of all medication incidents has affected the home's management in reducing and preventing medication incidents and in improving the care and treatment of residents with a specific health condition.

Sources: Review of a resident's MIR and interview with the DOC. [665]

COMPLIANCE ORDER CO #001 ADMINISTRATION OF DRUGS

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1) Develop and implement a process to ensure residents are administered the appropriate vaccines as prescribed, which includes review of resident(s)' immunization status prior to administration of vaccines.

2) Re-train registered staff on one Resident Home Area (RHA) on the process of re-ordering a specific medication from pharmacy.

3) Maintain a record of the training conducted, contents of the training, the trainer, staff that were trained and the date(s) of the training.

4) Conduct one audit to ensure that residents who have a medical order for a specific medication are available for the resident(s).

5) Maintain a record of the audit conducted, residents who were audited, the auditor, date of the audit, results of the audit and any actions taken to address the audit

findings.

Grounds

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

1) Rationale and Summary

Five residents had medical orders to administer two different types of vaccines. The residents received an additional dose of the vaccines by two registered staff as follows:

• Two residents received one of the vaccines and;
• Three residents received both vaccines.

The Infection Prevention and Control (IPAC) Lead, Resident Assessment Instrument (RAI) Coordinator and DOC stated that an incorrect resident list was used to vaccinate the residents. Additionally, the staff indicated that the residents' clinical records were not reviewed to confirm their vaccination status prior to administrering the vaccines. They verified that the residents received the vaccination not as prescribed.

The residents were at risk of adverse drug reaction when the vaccines were administered not as prescribed.

Sources: Review of the residents' MIRs and medical orders and interviews with IPAC Lead, RAI Coordinator and DOC. [665]

2) Rationale and Summary

The home submitted a critical incident to the MLTC for the use of a medication which resulted in a resident's transfer to hospital.

A medical order directed registered staff to administer a medication to treat a health condition. However, an RPN administered another treatment to manage the resident's health condition.

The RPN and an RN indicated that the medication was not administered as prescribed as it was not available in the RHA. The staff stated that the medication was not re-ordered from pharmacy.

Failure to administer the medication as prescirbed placed the resident at risk of harm in the management of their health condition.

Sources: Review of CI report, a resident's clinical records and interviews with the RPN, RN and other staff. [665]

This order must be complied with by May 16, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.