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:** October 3, 2024

**Inspection Number:** 2024-1709-0003

**Inspection Type:**
Complaint
Critical Incident

**Licensee:** Humber Meadows Long-Term Care Home

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

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 4-6, 9-12, 2024.

The following Complaint intake(s) were inspected:

- Intake: #00120833 - Related to neglect of wound care, plan of care, call bell system

The following Critical Incident intake(s) were inspected:

- Intake: #00122006 - [3065-000043-24] - Related to a fall resulting in injury
- Intake: #00120175 - [3065-000039-24] - Related to improper care, neglect
- Intake: #00121481 - [3065-000042-24] - Related to improper medication administration
- Intake: #00124124 - [3065-000048-24] - Related to disease outbreak

The following intake(s) were completed:

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

Intake(s): #00118989 - [3065-000035-24] and #00123908 - [3065-000046-24] - Related to falls prevention and management

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

Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
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) (a)**
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,
(a) the planned care for the resident;

The licensee has failed to ensure a resident's care plan included strategies and interventions in managing their refusal of a specific care need.

**Rationale and Summary**
A resident was scheduled to a specific care need and refused them multiple times over a specific period of time.

The Behaviour Support Ontario (BSO) lead indicated the refusal of the specific care need was a responsive behaviour, and that they contacted an external Behavioural Support Outreach Team (BSOT) for further assistance.

On a specific date, the BSO lead received a report from external BSOT. The BSO lead indicated they had a staff huddle and shared strategies and interventions to use when assisting the resident with the specific care need. They acknowledged the resident's care plan was not updated.

The Assistant Director of Care (ADOC) confirmed that the resident's care plan should have been updated by the BSO lead immediately following the staff huddle.

Failing to update the resident's care plan resulted in staff not being provided with strategies and interventions in managing the resident's refusal of a specific care need.

**Sources:** Resident's clinical records, Interviews with BSO lead and ADOC.

## WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)**
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure a resident's altered skin integrity was assessed on a weekly basis by a registered staff.

**Rationale and Summary**
An initial skin and wound assessment was performed on the same day a resident exhibited altered skin integrity.

The weekly assessments for the altered skin integrity were, however, not performed on multiple dates. This was acknowledged by an RN.

Failing to assess the resident's altered skin on at least a weekly basis placed them at risk of nursing staff not knowing the progress of the wound.

**Sources:** Resident's clinical records, Interview with RN.

## WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)**
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure any standard or protocol issued by the Director was implemented.

Specifically, the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes April 2022 (IPAC Standard), revised September 2023, section 9.1 b) under Routine Practices for hand hygiene (HH) was not implemented by a PSW and a Registered Practical Nurse (RPN) as per the four moments of HH.

**Rationale and Summary**

1) A PSW exited a resident room and walked down the corridor, accompanying the resident. The PSW did not complete HH upon exiting the resident's room.

The PSW acknowledged they should have completed HH when they exited the room and had failed to do so.

Failure of the PSW to complete HH when exiting the resident environment posed a risk of transmission of infectious disease in the long-term care home (LTCH).

**Sources:** Observation, Interview with PSW.

2) An RPN was observed touching a resident's arm while providing assistance, and moving their equipment. The RPN then touched the medication cart and did not complete HH between touching the resident and their equipment, and the medication cart.

The RPN acknowledged they should have completed HH after contact with the resident and their equipment, and that they failed to do so.

Failure of the RPN to complete HH posed a risk of transmission of infectious disease in the LTCH.

**Sources:** Observation, Interview with RPN.

## WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 102 (8)**
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that staff participated in the implementation of the home's IPAC program.

**Rationale and Summary**
A resident had symptoms of infection documented over a specific period of time.

A family member contacted the IPAC lead about the resident's symptoms and only then were additional precautions initiated.

The IPAC lead and Director of Care (DOC) both confirmed that the resident was placed on additional precautions on the day the family member called the home, and both acknowledged that they did not receive an earlier report about the resident's symptoms of infection.

The LTCH's policy indicated that registered staff must place symptomatic residents on additional precautions and report symptoms to the DOC or IPAC lead.

Failure to ensure that staff members participated in the implementation of the home's IPAC program, that included placing the resident on additional precautions and reporting their symptoms to the DOC or IPAC lead, posed a risk of transmission of infectious disease to other residents.

**Sources:** Resident's clinical records, Guideline for Respiratory Infection Policy, Interviews IPAC lead and DOC.

## WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)**
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection for a resident were monitored.

**Rationale and Summary**
A resident was on isolation precautions over a specific period of time due to symptoms of infection. Their clinical records noted that symptom monitoring was to be completed every shift. Documentation of the resident's symptoms of infection was not completed on multiple shifts.

An RN reviewed the resident clinical records, and confirmed their symptoms of infection were not documented on multiple shifts.

Failure of the LTCH to monitor symptoms of infection of a resident on isolation precautions posed a risk of a delayed response to a potential change in the resident's health status.

**Sources:** Resident's clinical records, Interview with RN.

## WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**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 licensee has failed to ensure a resident was administered a medication in accordance with the directions for use as written by the attending physician.

**Rationale and Summary**
A resident's clinical records indicated an order for a scheduled medication that was to be held if a value was below a specific parameter.

At a specific date and time, RN #116 documented a value for the resident below the specific parameter and signed off the scheduled dose as being administered. A short time later, a second RN recorded the resident's change in health status. The resident was transferred to another facility.

The home's investigation notes indicated RN #116 acknowledged the medication should not have been administered given the parameter set out in the medication order, and that administering the medication resulted in the resident being transferred to another facility.

The DOC confirmed RN #116 did not follow the medication order when they administered the medication to the resident on that specific date.

Failing to ensure RN #116 administered the medication as specified by the attending physican resulted in the resident experiencing an acute incident.

**Sources:** Resident's clincal records, home's investigation notes, Interview with DOC.