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 20, 2024

Inspection Number: 2024-1709-0004

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): October 28-31, 2024 and November 1, 4-7, 12-13, 2024.

The following intake(s) were inspected in this Critical Incident (CI) inspection:

- Intake: #00119313 - [CI: 3065-000037-24] - was related to medication management

The following intake(s) were inspected in this complaint inspection:

- Intake: #00125763 - was related to pest control, fall prevention and management, alleged abuse and neglect, skin and wound prevention and management, staffing, and resident care and support services
- Intake: #00125910 - was related to pest control and resident care and support services

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

- Intake: #00126168 - [CI: 3065-000057-24], Intake: #00127351 - [CI: 3065-000059-24], Intake: #00128508 - [CI: 3065-000062-24] - were related to falls prevention and management

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

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)
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; or

The licensee has failed to ensure that a resident was reassessed, and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs changed.

Rationale and Summary

A resident's plan of care on October 30, 2024, indicated that they required a certain level of assistance for activities of daily living (ADLs). On October 30 and October 31, 2024, the resident was observed being provided with a different level of assistance for the ADLs.

The resident home area (RHA) manager indicated that the resident was assessed by the physiotherapist and nursing team and the resident required a different level of assistance for ADLs, however the care plan was not updated. They indicated that the plan of care was updated on October 31, 2024, to reflect the resident's care needs.

Failure to revise the resident's plan of care to include the current required level of assistance for ADLs when the resident's care needs changed, provided minimal risk to the resident.

Sources: Resident's care plan; observations; interview with RHA manager, and other staff.

[741073]

Date Remedy Implemented: October 31, 2024

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)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided

to the resident as specified in the plan.

The licensee has failed to ensure that a certain level of assistance with an ADL was provided to a resident as specified in their plan of care.

Rationale and Summary

A complaint was received by the Ministry of Long-Term Care regarding a fall of a resident. The resident had an unwitnessed fall. When the home reviewed the closed circuit television (CCTV) footage, the resident was seen completing an ADL without an assistive device and lost their balance and fell.

The resident's plan of care indicated that they required a certain level of assistance with the ADL.

A Personal Support Worker (PSW) indicated that they last saw the resident 30 minutes prior to the fall, completing the ADL with their assistive device with no staff present. The PSW indicated that they left the resident to attend to a co-resident.

The PSW, RHA manager, and the Director of Care (DOC) acknowledged that when the resident was seen completing the ADL, they were to be provided with the appropriate level of assistance. The PSW, RHA manager, and the DOC indicated that the PSW should have called another staff member to provide assistance while the resident completed the ADL unsupervised.

Failure to provide assistance with the ADL for the resident as specified in their plan of care, put the resident at risk for a fall and injury.

Sources: Resident's clinical records; interviews with PSW, RHA Manager, DOC and other staff.

[741073]

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
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,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that when a resident exhibited altered skin integrity, they received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument specifically designed for skin and wound assessment.

Rationale and Summary

A resident was observed having altered skin integrity, which was documented by a Registered Nurse (RN).

The home's policy directed registered staff to assess altered skin integrity by completing the electronic Skin & Wound Assessment using the Point Click Care (PCC) Skin & Wound Application.

The resident's clinical records indicated that no Skin & Wound Application assessment for the altered skin integrity was completed.

The RN, RHA Manager, and the DOC acknowledged that a skin and wound assessment was not completed for the altered skin integrity, and that it should have been completed when the altered skin integrity was first discovered.

Failure to complete a skin and wound assessment for the resident who exhibited alerted skin integrity, put the resident at risk for not receiving the appropriate treatment promptly and further skin breakdown.

Sources: Resident's clinical records; home's policy "Skin & Wound Care Management Protocol", VII-G-10.90, revised October 17, 2023; interviews with RN, RHA Manager, and DOC.

[741073]

WRITTEN NOTIFICATION: Administration of drugs

NC #004 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 that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

Two of a resident's prescribed medications were ordered to be held before going to

the hospital. The resident was discharged from the hospital with instructions to continue the two medications. Registered staff did not complete the medication reconciliation when the resident returned from the hospital and the two medications were not continued.

21 days later, the resident experienced a change in their health condition and was transferred to the hospital. The hospital discharge summary indicated that the resident's condition was “likely provoked” by the absence of the administration of one of the two medications.

Review of the medication administration record (MAR) and confirmation by the RHA Manager confirmed that the resident did not receive the two medications in the home for 21 days, after the discharge summary and after hospital instructions indicated to continue the medications.

The RHA Manager indicated that the registered staff did not reconcile the discharge orders with the attending physician when the resident returned from the hospital. This resulted in the resident not receiving the two prescribed medications.

The resident was at increased risk of experiencing a change in health condition when the two medications were not administered as specified by the prescriber for 21 days.

Sources: CIS Report #3065-000037-24; Resident’s clinical records; the home’s investigation notes; MediSystem policy "Medication Reconciliation Policies and Procedures", 04-05-04; interviews with RN, RHA Manager, and the DOC.

[741073]

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