Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 17, 2017	2017_644507_0012	022999-17	Resident Quality Inspection

Licensee/Titulaire de permis

HERITAGE NURSING HOMES INC.
1195 QUEEN STREET EAST TORONTO ON M4M 1L6

Long-Term Care Home/Foyer de soins de longue durée

THE HERITAGE NURSING HOME
1195 QUEEN STREET EAST TORONTO ON M4M 1L6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

STELLA NG (507), ADAM DICKEY (643)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 2, 3, 4, 5 and 6, 2017.

The following complaint was inspected concurrently with the RQI: #033160-15 related to plan of care, abuse prevention and foot care and nail care.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), registered dietitian (RD), director of residents and family services, building services manager (BSM), housekeeping aide (HKA), activation manager (AM), activity aide (AA), business office manager (BOM), residents, substitute decision makers (SDMs) and family members of residents.

The inspectors conducted tour of the home, observations of staff and resident interactions, provision of care, medication administration, record review of resident and home records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **3 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked to prevent unsupervised access when they were not supervised by staff.

A) Observations by the inspector on an identified unit on an identified date revealed a door labelled utility room equipped with a keypad lock was able to be opened without entering the code. Observation of the room revealed that there were personal care products including shampoo, shave cream, razors, continence products and mouthwash present. The door was observed to be locked if pushed closed but not if allowed to close automatically.

In an interview, staff #114 stated that the utility room door is normally locked, and that the door is expected to be closed and locked to prevent resident access to the room.

Observations by the inspector on the same unit revealed a room located next to an identified resident room with an unlocked door, the door lock was blocked by a napkin stuffed in the locking mechanism. Observation of the room revealed a mop sink, cleaning supplies, and chemicals including:
- Chemsyn Earth Tone odour controller,
- Virudex-7 disinfectant, and
- Europa cleanser.

In an interview, staff #115 stated that this door should be kept locked at all times to prevent resident access to cleaning products stored inside. In an interview, staff #116 stated that this door was normally kept closed to prevent resident access. Staff #116 additionally stated that he/she placed the napkin in the door when stocking the cleaning cart and had forgotten to remove the napkin.

B) Observations by the inspector on a second identified unit revealed a door labelled utility room equipped with a keypad lock was able to be opened without entering the code.

Observation of the room revealed there were personal care products including shampoo, shave cream, razors, continence products and mouthwash inside. The door was observed to be locked if pushed closed but not if allowed to close automatically.

In an interview, staff #117 stated that this door was normally locked and that the door would lock if pushed closed.

C) Observations by the inspector on a third identified unit revealed a room located next to an identified resident room with an unlocked door, the door lock was blocked by a napkin stuffed in the locking mechanism. Observation of the room revealed a mop sink, cleaning supplies, and chemicals including:
- Chemsyn Earth Tone odour controller,
- Virudex-7 disinfectant,
- Europa cleanser,
- Venus Pro-crème, and
- Clorox urine remover.

In an interview, staff #118 stated that this door should be kept locked at all times and that he/she had placed the napkin in the door to prevent it from locking to make it easier to stock his/her cleaning supplies.

Observations by the inspector on the same unit revealed a door labelled utility room equipped with a keypad lock was able to be opened without entering the code. Observation of the room revealed there were personal care products including shampoo, shave cream, razors, continence products and mouthwash inside.

D) Observations by the inspector on a fourth identified unit revealed a door labelled utility room equipped with a keypad lock was able to be opened without entering the code. Observation of the room revealed there were personal care products including shampoo, shave cream, razors, continence products and mouthwash inside. An unlocked treatment cart was placed inside the utility room, containing supplies including scissors. Staff #119 stated that this door should be kept locked to prevent resident access to the room.

In an interview, staff #100 stated that he/she was unaware that the utility rooms on each floor would remain unlocked unless pushed closed. He/she further stated that this issue would be addressed immediately.

In an interview, staff #101 stated that it was the expectation of the home to keep the housekeeping rooms and utility rooms locked to prevent resident access. Staff #101 acknowledged that the home had failed to ensure that these doors leading to non-residential areas were kept closed and locked to prevent unsupervised access when they were not supervised by staff.

The severity is potential for actual harm, and the scope is widespread. As a result, a Compliance Order is warranted. [s. 9. (1) 2.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident height is measured and recorded annually.

During stage one of the resident quality inspection (RQI) record reviews for residents in the census sample revealed that 20/20 residents in the sample did not have a height measured and recorded in the past year. Review of the census record information revealed that 20/20 of the sample residents did not have a height measured and recorded for over three years.

Review of the home's policy titled "Monitoring Residents Weight and Height" dated September 2016, revealed that each resident's height was to be taken on admission and annually thereafter and entered into the resident's chart.

In interviews, staff #104 and #111 stated that they were aware of the requirement that heights are to be measured annually, but indicated that this was not the practice in place in the home.

In an interview, staff #112 stated that he/she was aware of the policy in the home stating that heights are to be taken annually after admission. Staff #112 further stated that he/she would base assessments on the height that was on file since admission in most cases. Staff #112 stated that in a continuous quality improvement (CQI) meeting it was discussed that the heights should be measured annually but the process had not been implemented.

In an interview, staff #120 stated that it was the expectation of the home for resident heights to be measured and recorded annually. Staff #120 further stated that measuring tape had been provided to each unit to complete the heights measurement but the process was not yet in place. Staff #120 acknowledged that the home had not measured and recorded heights for each resident annually.

The severity is minimum risk, and the scope is widespread. As a result, a Compliance Order is warranted. [s. 68. (2) (e) (ii)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident's right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act, was fully respected and promoted.

Review of the home's policy titled "Medication Management System" revised November 2016, indicated that after removing the medication from its container or blister pack, staff should ensure that any resident identifiable information, e.g. medicine labels, is destroyed or totally obscured before sending to recycle bins.

In interviews, staff #105 told the inspector that he/she wrapped the empty labeled blister packs in a piece of kleenex prior to putting them in a regular garbage bin. Staff #106 told and demonstrated to the inspector that he/she usually cuts the labels in half, then places them in a regular garbage bin. The inspector and staff #106 were able to read the name of the resident and the medication on the cut labels.

In an interview, staff #120 stated that staff were instructed to remove the labels from the empty blister packs, place the labels on a piece of paper, then place the paper with labels in the shredder. Staff #120 acknowledged that staff #105 and #106's actions in placing the labels from the empty blister packs in the regular garbage bins was a violation of respecting the resident's right. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident's right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act, is fully respected and promoted, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

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

Review of the physician's order on an identified date and the electronic medication administration record (eMAR) for an identified month for resident #007 revealed the resident was prescribed an identified medication of an identified dose by mouth at two identified scheduled times (time A and time B), the same medication of double dose by mouth at a third identified scheduled time (time C).

Review of the home's medication error/ dispensing discrepancy reports revealed that resident #007 was administered the above mentioned medication of double dose by mouth at time A on two identified days in the above mentioned month. The report further stated that resident #007 did not experience any side effect after the medication administration on both above mentioned dates.

In an interview, staff #106 told the inspector that he/she administered the above mentioned medication of double dose by mouth to resident #007 at time A on one of the above mentioned identified dates. Staff #106 further stated that resident #007 was not prescribed the above mentioned medication at double dose by mouth at time A.

In an interview, staff #120 confirmed that resident #007 was prescribed the above mentioned medication of identified dose by mouth at two identified scheduled times (time A and time B), and the medication of double dose by mouth was administered at time A on two above mentioned identified dates by mistake.
[s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed.

Review of the home's medication error/ dispensing discrepancy reports revealed that resident #007 was administered an identified medication of an identified dose by mouth instead of half of the dose by mouth as prescribed at an identified scheduled time on two identified dates.

Review of the above mentioned medication error/ dispensing discrepancy reports failed to reveal an analysis of the incidents.

In an interview, staff #120 acknowledged the above mentioned medication incidents were not analyzed as required. [s. 135. (2)]

2. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

Review of the home's inter-department meeting minutes on an identified date failed to reveal a quarterly review of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

In an interview,staff #120 confirmed that a quarterly review of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions was not conducted. [s. 135. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed, and b) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

Review of the home’s policy titled "Medication Management System" revised November 2016, indicated nurses involved in medication administration must be knowledgeable and competent in infection prevention, effective hand hygiene, safe injection practices and the use of aseptic techniques including hand hygiene between resident contacts during medication administration.

On an identified date, the inspector was assisted by staff #105 in conducting the observation in the medication room by opening the locked medication cabinets on an identified unit. After leaving the medication room, the inspector observed staff #105 prepared and administered medication to resident #012 without performing hand hygiene.

In an interview, staff #105 stated that he/she should have performed hand hygiene prior to medication administration, but he/she did not do so.

In an interview, staff #120 stated that it was the home’s expectation to perform hand hygiene prior to having any resident contact and care between residents. Staff #120 confirmed that it was not acceptable to prepare and administer medication to a resident after touching the counter surfaces without performing hand hygiene. [s. 229. (4)]

Issued on this 30th day of October, 2017

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	STELLA NG (507), ADAM DICKEY (643)
Inspection No. / No de l'inspection :	2017_644507_0012
Log No. / No de registre :	022999-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 17, 2017
Licensee / Titulaire de permis :	HERITAGE NURSING HOMES INC. 1195 QUEEN STREET EAST, TORONTO, ON, M4M-1L6
LTC Home / Foyer de SLD :	THE HERITAGE NURSING HOME 1195 QUEEN STREET EAST, TORONTO, ON, M4M-1L6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JORDAN GLICK

To HERITAGE NURSING HOMES INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii.equipped with a door access control system that is kept on at all times, and
   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

Upon receipt of this compliance order the licensee shall:
1. Ensure that all doors leading to non-residential areas are kept closed and locked when not in use.
2. Develop and implement an auditing system in the home to ensure that all doors leading to non-residential areas are kept closed and locked when not in use.

Grounds / Motifs :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked to prevent unsupervised access when they were not supervised by staff.

A) Observations by the inspector on an identified unit on an identified date revealed a door labelled utility room equipped with a keypad lock was able to be opened without entering the code. Observation of the room revealed that there were personal care products including shampoo, shave cream, razors, continence products and mouthwash present. The door was observed to be locked if pushed closed but not if allowed to close automatically.

In an interview, staff #114 stated that the utility room door is normally locked, and that the door is expected to be closed and locked to prevent resident access to the room.

Observations by the inspector on the same unit revealed a room located next to an identified resident room with an unlocked door, the door lock was blocked by a napkin stuffed in the locking mechanism. Observation of the room revealed a mop sink, cleaning supplies, and chemicals including:
- Chemsyn Earth Tone odour controller,
- Virudex-7 disinfectant, and
- Europa cleanser.

In an interview, staff #115 stated that this door should be kept locked at all times to prevent resident access to cleaning products stored inside. In an interview, staff #116 stated that this door was normally kept closed to prevent resident access. Staff #116 additionally stated that he/she placed the napkin in the door when stocking the cleaning cart and had forgotten to remove the napkin.

B) Observations by the inspector on a second identified unit revealed a door labelled utility room equipped with a keypad lock was able to be opened without

entering the code.

Observation of the room revealed there were personal care products including shampoo, shave cream, razors, continence products and mouthwash inside. The door was observed to be locked if pushed closed but not if allowed to close automatically.

In an interview, staff #117 stated that this door was normally locked and that the door would lock if pushed closed.

C) Observations by the inspector on a third identified unit revealed a room located next to an identified resident room with an unlocked door, the door lock was blocked by a napkin stuffed in the locking mechanism. Observation of the room revealed a mop sink, cleaning supplies, and chemicals including:
- Chemsyn Earth Tone odour controller,
- Virudex-7 disinfectant,
- Europa cleanser,
- Venus Pro-crème, and
- Clorox urine remover.

In an interview, staff #118 stated that this door should be kept locked at all times and that he/she had placed the napkin in the door to prevent it from locking to make it easier to stock his/her cleaning supplies.

Observations by the inspector on the same unit revealed a door labelled utility room equipped with a keypad lock was able to be opened without entering the code. Observation of the room revealed there were personal care products including shampoo, shave cream, razors, continence products and mouthwash inside.

D) Observations by the inspector on a fourth identified unit revealed a door labelled utility room equipped with a keypad lock was able to be opened without entering the code. Observation of the room revealed there were personal care products including shampoo, shave cream, razors, continence products and mouthwash inside. An unlocked treatment cart was placed inside the utility room, containing supplies including scissors. Staff #119 stated that this door should be kept locked to prevent resident access to the room.

In an interview, staff #100 stated that he/she was unaware that the utility rooms

on each floor would remain unlocked unless pushed closed. He/she further stated that this issue would be addressed immediately.

In an interview, staff #101 stated that it was the expectation of the home to keep the housekeeping rooms and utility rooms locked to prevent resident access. Staff #101 acknowledged that the home had failed to ensure that these doors leading to non-residential areas were kept closed and locked to prevent unsupervised access when they were not supervised by staff.

The severity is potential for actual harm, and the scope is widespread. As a result, a Compliance Order is warranted. (643)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 29, 2017

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;
(b) the identification of any risks related to nutrition care and dietary services and hydration;
(c) the implementation of interventions to mitigate and manage those risks;
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Order / Ordre :

Upon receipt of this compliance order the licensee shall:
1) Ensure that for each resident height is measured and recorded annually.
2) Review and revise policies and procedures to clearly indicate the role of staff members in ensuring that each resident's height is measured and recorded annually.
3) Develop and implement an auditing system to ensure that each resident's height is measured and recorded annually.

Grounds / Motifs :

1. The licensee has failed to ensure that for each resident height is measured and recorded annually.

During stage one of the resident quality inspection (RQI) record reviews for residents in the census sample revealed that 20/20 residents in the sample did not have a height measured and recorded in the past year. Review of the census record information revealed that 20/20 of the sample residents did not have a height measured and recorded since January 31, 2014.

Review of the home's policy titled "Monitoring Residents Weight and Height" dated September 2016, revealed that each resident's height was to be taken on admission and annually thereafter and entered into the resident's chart.

In interviews, registered nurses (RN) #104 and #111 stated that they were aware of the requirement that heights are to be measured annually, but indicated that this was not the practice in place in the home.

In an interview, registered dietitian (RD) #112 stated that he/she was aware of the policy in the home stating that heights are to be taken annually after admission. The RD further stated that he/she would base assessments on the height that was on file since admission in most cases. The RD stated that in a continuous quality improvement (CQI) meeting it was discussed that the heights should be measured annually but the process had not been implemented.

In an interview, DOC #120 stated that it was the expectation of the home for resident heights to be measured and recorded annually. The DOC further stated that measuring tape had been provided to each unit to complete the heights measurement but the process was not yet in place. The DOC acknowledged that the home had not measured and recorded heights for each resident annually.

The severity is minimum risk, and the scope is widespread. As a result, a Compliance Order is warranted. (643)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 15, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 17th day of October, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector / Nom de l'inspecteur : STELLA NG

Service Area Office / Bureau régional de services : Toronto Service Area Office