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 prévue 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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
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Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 17, 2019	2019_634513_0010	032970-18, 012249-19	Critical Incident System

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

JUDITH HART (513)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 27, 28, July 2, 3, 4, and 5, 2019.

During the course of the inspection, the following intake logs were inspected: #012249-19, related to a change in a resident's condition, and #032970-18, related to a fall.

During the course of the inspection, the inspector(s) spoke with the Director of Care, Supervisor, Registered Practical Nurses (RPNs), Personal Services Workers (PSWs), residents, the Coroner and family members.

The inspector reviewed resident records, staffing lists, and documents the home sent to the Coroner.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 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	Légende 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee has failed to ensure that any policy instituted or otherwise put in place was complied with.

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care for a fall in 2019. The CIS indicated resident #001 had a fall that caused an injury, for which the resident was taken to hospital and passed away.

In accordance with O. Reg. 79/10, s.48 (1) 1. and in reference to O. Reg. s. 49 (1), the licensee was required to have a Falls Prevention and Management Program that provided for strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the licensee's falls prevention policy, which required staff to conduct a head injury routine for each unwitnessed fall as part of their strategies for monitoring residents, notify the physician as soon as possible of the fall, notify the next of kin of the fall and monitor the resident for 48 hours if the resident was on specific medications.

A review of the care plan on a specified date indicated resident #001 was at a high risk for falls. The care plan indicated the resident tried to get up on their own from the bed and chair and a sensor alarm was placed on the resident to alert staff.

A review of the Minimum Data Set (MDS) for resident #001 indicated the resident was cognitively intact. The resident required extensive one-person physical assist with transfers and mobility, and was dependent for locomotion.

A review of the Medication Administration Record (MAR) for resident #001 indicated the

medication therapy included a daily medication to treat a medical condition.

A review of the home's video footage on a specified date showed resident #001 exiting their room; walking while touching an item in the hallway and while reaching for a chair fell to the floor in a sitting position, rolled to the side and then sat up again. Staff came and attended to the resident.

An interview with PSW #101 indicated the resident wanted to go to bed. The PSW provided care to resident #001. PSW #101 walked down the hall to care for another resident and was alerted by the resident's alarm, came into the hallway and saw resident #001 sitting on the floor, saw no bleeding and notified the charge nurse, RPN #102. The resident was assessed by RPN #102 and PSW #101, with a colleague, transferred the resident to a mobility device.

An interview with Registered Practical Nurse (RPN) #102 indicated that when resident #001 fell, an assessment was completed, the resident denied pain, was able to answer questions and follow commands. RPN #102 indicated HIR was not initiated as the resident stated, when asked, they did not hit their head when they fell, the POA was not informed nor was this endorsed to the oncoming staff and a specific medication for a medical condition was not recalled.

An interview with Registered Nurse (RN) #107 indicated, when a resident has fallen, the protocol is to take vital signs (VS) and call the family and doctor. If the fall is not witnessed and if the resident is not cognitively impaired the HIR is not done. If the resident is cognitively impaired HIR is started and VS are taken.

An interview with the Director of Care (DOC) indicated the home's expectation when a resident has had an unwitnessed fall is to notify the POA and physician, and conduct HIR as per the home's policy. In this instance HIR was not initiated by the registered staff, therefore not following the home's policy.

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the designate of the resident / Substitute Decision Maker (SDM) has been provided the opportunity to participate fully in the development and implementation of the plan of care.

A review of the progress notes by registered staff #102 identified resident #001 had fallen on a specified date in 2019, and was found sitting in the hallway outside the resident's room. Vital signs were taken and a head to toe assessment completed. Resident #001 denied hitting their head and denied pain and discomfort. The progress note did not identify that the SDM was called to report that the resident had fallen.

An interview with registered staff #102 identified that the SDM was not called as the fall occurred at a specific time and the fall was not severe. RPN #102 said that since the fall was at the end of the shift they thought the following staff would call, although this was not communicated to the oncoming shift. Now, having discussed this incident with the DOC, RPN #102 will notify the family for all falls that occur when working the specific shift.

An interview with the DOC confirmed that resident #001's fall was not communicated to the SDM after the resident's fall until a specified time. They confirmed that the SDM was notified of the resident's condition and transfer to hospital at this specified time. The DOC stated that resident #001's fall was discussed with RPN #102 and that RPN #102 confirmed to the DOC that the SDM was not notified by RPN #102, therefore, not ensuring that the SDM had been provided the opportunity to participate fully in the development and implementation of resident #001's plan of care. [s. 6. (5)]

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 the designate of the resident / Substitute Decision Maker (SDM) is provided the opportunity to participate fully in the development and implementation of the plan of care, to be implemented voluntarily.

Issued on this 22nd day of July, 2019

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

Ministère de la Santé et des Soins de longue durée

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JUDITH HART (513)
Inspection No. / No de l'inspection :	2019_634513_0010
Log No. / No de registre :	032970-18, 012249-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 17, 2019
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:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, r. 8(1)(b), of the Long-Term Care Homes Act.

Specifically, the licensee must:

1. Provide education to every registered staff who works in the home on the Fall Management Program policy, Section B7, Step #2, to ensure the post fall management monitoring routine for each fall, specifically for Head Injury Routine (HIR), is understood by staff to include but is not limited to:
   a. When HIR is to be initiated,
   b. Frequency of HIR, and
   c. Rationale for HIR when a resident is receiving an identified type of medication;

2. Provide education on persons to be notified of the resident's fall; and

3. The home is to keep a documented record of the education that includes but is not limited to: date, content, education method, person responsible, person who provided the education and name of staff who received the education.

Grounds / Motifs :

1. The licensee has failed to ensure that any policy instituted or otherwise put in place was complied with.

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care for a fall in 2019. The CIS indicated resident #001 had a fall that caused an injury, for which the resident was taken to hospital and passed away.

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A review of the Minimum Data Set (MDS) for resident #001 indicated the resident was cognitively intact. The resident required extensive one-person physical assist with transfers and mobility, and was dependent for locomotion.

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A review of the home's video footage on a specified date showed resident #001 exiting their room; walking while touching an item in the hallway and while reaching for a chair fell to the floor in a sitting position, rolled to the side and then sat up again. Staff came and attended to the resident.

An interview with PSW #101 indicated the resident wanted to go to bed. The PSW provided care to resident #001. PSW #101 walked down the hall to care for another resident and was alerted by the resident's alarm, came into the

hallway and saw resident #001 sitting on the floor, saw no bleeding and notified the charge nurse, RPN #102. The resident was assessed by RPN #102 and PSW #101, with a colleague, transferred the resident to a mobility device.

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An interview with the Director of Care (DOC) indicated the home's expectation when a resident has had an unwitnessed fall is to notify the POA and physician, and conduct HIR as per the home's policy. In this instance HIR was not initiated by the registered staff, therefore not following the home's policy.

The severity of this was determined to be a level four as there was serious harm to the resident. The scope was isolated to one of three residents reviewed. The home had a level two compliance history with previous non-compliance to a different subsection of the LTCHA, O. Reg. 79/10.
As a result of serious harm to the resident, a compliance order is warranted.

(513)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 06, 2019

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

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 July, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Judith Hart

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