Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 29, 2020	2020_769646_0002	022984-19	Complaint

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

IVY LAM (646)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 17, 20, and 21, 2020.

A complaint intake #022984-19 was inspected, regarding concerns of a resident's catheter care requiring hospitalization.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), physicians, registered nurse (RN), registered practical nurses (RPN), and personal support worker (PSW).

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

This inspection was initiated related to a complaint submitted to the Ministry of Long-Term Care (MLTC) related to resident #001 who was transferred to the hospital for an identified procedure and passed away two days later in the hospital.

Review of resident's progress notes showed that resident #001 was scheduled to have the identified procedure done in the home the day before the resident was sent to the hospital by the Nurse Led Outreach Team (NLOT) nurse, and this was done for resident #001. On the next shift the same day, Registered Practical Nurse (RPN) #105 documented that a Personal Support Worker (PSW) had informed the RPN of an identified issue with resident #001's procedure. The progress notes further stated Registered Nurse (RN) #106 had tried to assist the resident with the identified procedure but noted that the resident had an identified response and did not continue to perform the identified procedure. The NLOT nurse was called and stated they would come at an identified time the next day and was endorsed to the nurse on the next shift to monitor the resident closely. On the same day, the RPN on the next shift documented at the end

of their shift and the resident had an identified response when they were provided with an identified care.

On the next day, RPN #100, documented in the progress notes that the resident had an identified response when the resident was provided with an identified care.

Review of the progress notes and the PointClickCare (PCC) vitals record on the day that the issue was identified with the resident #001's procedure, showed the resident's temperature was not taken. No vitals were recorded on the next two shifts for the resident.

On the day the resident was sent to the hospital, RPN #104 documented in the progress notes that the NLOT nurse was unable to perform the identified procedure for the resident, and the resident had continued to have an identified response. The resident's vitals were taken, the resident's temperature was taken, and the resident did not have a fever. The nurse supervisor was notified, and the physician was informed, and the resident was sent to the hospital due to continued have the identified response.

Review of the resident's hospital discharge notes showed resident #001 had passed away two days after they were sent to the hospital with an identified discharge diagnosis.

Interview with RPN #105 stated that the usual process when a resident had the above-identified response would be for the RPN to call the RN supervisor, and follow their instructions, then call the physician, determine whether the resident needs to be sent out, to take the resident's vitals, and determine if the resident needs to be sent out earlier based on any unusual findings from the vitals. RPN #105 stated that the evening when the issue was identified with resident #001's procedure, they notified the RN supervisor, who tried to perform the identified procedure for the resident but could not and the resident had an identified response. The RPN was not able to recall the temperature but stated the resident likely did not have a fever, or else they would notify the physician. RPN #105 further stated they had not notified the physician of the identified issue with the procedure or the resident's response because the supervisor did not give directions to call the physician, only to call the NLOT nurse. The RPN further stated they could have called the physician whether or not the RN had instructed the RPN to call.

Interview with RN #106 stated that when the issue was identified with the resident's procedure, and the resident was identified with the identified response, they would call the physician. They would also assess the resident for identified signs and symptoms.

They would advise the physician and provide appropriate care and monitoring for the resident, and document in the progress notes. On the day of the incident, the RN stated they were unable to provide the identified procedure for resident #001 and told the RPN to call the NLOT. They also notified the RPN to monitor the resident closely and had expected the RPN to call the physician if the resident had further issues. The RN had also expected the RPN to provide further assessments of the resident again on the shift, and to call the physician. The RN stated they did not know if the RPN had notified the physician.

Interview with physician #103 stated that they were not called on the day the resident had the identified issue with the procedure. The physician stated they were notified on the shift when resident #001 was being sent to the hospital. The physician further stated that had the registered staff called the physician when the issue with the procedure was first identified, the physician would have informed them to send the resident to the hospital to do the procedure that day, as the RN was not able to perform the identified procedure and the NLOT nurse would not be able to come in until the next day.

Interview with RPN #100 who worked on the day after the identified issue with the procedure stated the resident was up at meals and did not appear uncomfortable. The RPN had waited for the NLOT nurse to come on their shift but the NLOT nurse had not come. The RPN stated they had checked the resident twice on their shift and noted an identified response. However, the RPN further stated they had not notified the physician about resident #001 on their shift as there were no abnormal clinical symptoms for resident #001.

Interview with RPN #104 who had worked on the shift that resident #001 was sent to the hospital said that the NLOT nurse had come prior to the start of their shift. The RPN stated that they spoke with the NLOT nurse, who said they were not able to complete the identified procedure and suggested the RPN to send the resident to the hospital. The RPN notified the RN supervisor and assessed the resident. The RPN stated they were concerned while reading the progress notes that the resident had an issue with the identified procedure and the previous shifts had not notified the physician or sent the resident to the hospital.

Interview with the Director of Care (DOC) stated that they would have expected the staff to provide the appropriate monitoring and assessment, and to ensure that the information is recorded on PCC vitals or the progress notes if they had monitored the resident. The

DOC further stated they would expect the staff to notify the physician regarding the actions needed for a resident who had issues with the identified procedure and when the staff could not provide the identified procedure, and they did not. The DOC stated the staff had not communicated and collaborated in assessing resident #001 during the above-mentioned incident. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

Review of resident #001's progress notes showed signs for an identified condition. Physician #103 assessed resident #001 the next day and ordered an identified test. The resident was assessed by physician #103 again the day after and an identified medication was ordered for resident #001 for another health condition for a seven-day period, and the resident was to be monitored closely.

Review of resident #001's identified test results dated four days after it was ordered showed that the resident had positive test results. Review of the multidisciplinary progress notes showed that two days after the printed results, physician #103 had acknowledged the positive test results and stated the resident was already on the identified medication above.

Review of resident #001's Electronic Medication Administration Records (eMAR) on the identified month showed that the resident was provided the abovementioned medication as prescribed for a seven-day period.

Review of resident #001's progress notes and PCC records showed that there were no documentation of the resident's vitals or any monitoring specific to condition that the resident tested positive for on six day shifts, two evening, and two night shifts during the identified seven-day period above.

Review of the shift report between the identified seven-day period, showed that resident #001 was on the identified medication for another health condition, and did not mention the condition that the resident tested positive for.

In separate interviews with RPN #108 and RPN #105, they stated interventions to closely monitor a resident with the identified health condition included provision of the resident's

prescribed medication, to monitor the resident for further signs and symptoms and to notify the physician, and to provide appropriate care for the resident.

Interview with the DOC and physician #102, the home's medical director, showed that it is the home's expectation for staff to monitor and document on day and evening shift regarding the resident's vitals and condition while the resident is on the identified prescribed medication, and that this was not done for resident #001 while they were on the prescribed medication for the condition which they tested positive for during the identified seven-day period. The DOC further stated that the staff did not collaborate in developing and implementing a plan of care for resident #001's identified condition regarding the monitoring and documenting resident #001's vitals, any signs and symptoms, and interventions provided while the resident was on the identified medical therapy. [s. 6. (4) (b)]

3. The licensee has failed to ensure that the 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.

Review of resident #001's identified test results dated four days after it was ordered showed that the resident had positive test results. Review of the multidisciplinary progress notes showed that two days after the printed results, physician #103 had acknowledged the positive test results and stated the resident was already on the identified medication above.

Review of the resident's last care plan with revision history did not show any documentation regarding resident #001's change in condition when they had tested positive for the identified health condition, or any care interventions for the resident related to the condition.

Separate interviews with RPN #108 and RPN #105 stated that a resident's interventions for the identified health condition should be included in the care plan, and any registered staff could enter the information in the care plan. The RPNs further stated the interventions included provision of the resident's prescribed medication, to monitor the resident for further signs and symptoms and to notify the physician, and to provide the appropriate care for the resident. The RPNs stated resident #001's plan of care should be revised to include the above-mentioned interventions to address their identified health condition, and this was not done when the resident for the identified period above.

Interview with the DOC stated it is the home's expectation for staff to review and revise residents' plans of care when their conditions change, and this was not done for resident #001 during the identified period above. [s. 6. (10) (b)]

4. Resident #003 was inspected as part of the sample expansion to inspect the continence and bowel management.

Review of resident #003's progress notes showed that an identified symptom was noted for the resident on an identified date; the physician was informed, and an identified test was ordered the next day, with prescribed medications started for the resident on the same day.

Review of resident #003's eMAR showed the resident was prescribed an identified medication for seven days, and it began on the day identified above.

Separate interviews with RPN #108 and RPN #105 stated that a resident's interventions for the identified health condition should be included in the care plan, and any registered staff could enter the information in the care plan. The RPNs further stated the interventions included provision of the resident's prescribed medication, to monitor the resident for further signs and symptoms and to notify the physician, and to provide the appropriate care for the resident. The RPNs stated resident #003's plan of care should be revised to include the above-mentioned interventions to address their identified health condition, and this was not done when the resident for the identified period above.

Interview with the DOC stated it is the home's expectation for staff to review and revise residents' plans of care when their conditions change, and this was not done for resident #003 during the identified period above. [s. 6. (10) (b)]

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 staff and others involved in the different aspects of care of the resident collaborate with each other, (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and (b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other; and
- the resident is 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 change or care set out in the plan is no longer necessary, to be implemented voluntarily.

Issued on this 7th day of February, 2020

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

Original report signed by the inspector.