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: July 9, 2024
Inspection Number: 2024-1096-0002
Inspection Type: Critical Incident Follow up
Licensee: Heritage Nursing Homes Inc.
Long Term Care Home and City: The Heritage Nursing Home, Toronto

Lead Inspector	**Inspector Digital Signature**
Lisa Salonen Mackay (000761)	Lisa A Salonen Mackay Digitally signed by Lisa A Salonen Mackay Date: 2024.08.07 14:39:00 -04'00'

Additional Inspector(s)
Michael Chan (000708)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 11, 12, 13, 14, 17, 20, 21, 24, 25, 2024.

The following intake(s) were inspected:

- Intake: #00110311 - Follow-up Inspection to Compliance order (CO) #001: related to infection prevention and control
- Intake: #00116185 - Critical Incident (CI) - [2582-000013-24] was related to disease outbreak
- Intake: #00106397 - [CI: 2582-000003-24] - was related to fall with injury
- Intake: #00107412 - [CI: 2582-000004-24] and Intake: #00113383 - [CI: 2582-000011-24] were related to abuse.

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

- Intake: #00114942 - [CI: 2582-000012-24] and Intake: #00106256 - [CI: 2582-000002-24] were related to disease outbreak.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1096-0001 related to O. Reg. 246/22, s. 102 (8) inspected by Michael Chan (000708)

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in residents were recorded in accordance with any standard or protocol issued by the Director.

Rational and Summary:
The Director of Care (DOC) and the Infection Prevention and Control (IPAC) Lead both indicated that registered staff were to document signs and symptoms of infection in the progress notes at least once per shift. The DOC and IPAC Lead both indicated that there was no documentation on signs and symptoms for multiple residents on additional precautions across multiple shifts during an outbreak. Failure of the home to record symptoms indicating the presence of infection in residents may lead to the home's inability to monitor the health status of residents and intervene appropriately.

Sources: CI 2582-000013-24, interview with IPAC Lead, review of clinical records of residents.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 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 that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Specifically, the IPAC Standard for Long-Term Care Homes, s. 2.1, states that the licensee shall ensure that the IPAC Lead conducts at a minimum, quarterly real-time audits of specific activities performed by staff in the home, including, but not limited to, donning and doffing of Personal Protective Equipment (PPE).

Rationale and Summary:
A review of the home's IPAC audits did not indicate there were any audits conducted related to the donning and doffing of PPE. The IPAC Lead indicated that the home did not conduct quarterly audits performed related to donning and doffing of PPE.

Failure of the home to conduct audits of donning and doffing of PPE could lead to the home's inability to monitor staff compliance with IPAC practices in the home related to donning and doffing PPE.

Sources: Interviews with the home's management, record reviews of the audits.

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
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

The licensee failed to ensure that staff involved in the different aspects of care of the resident collaborated with each other in their assessments so that their assessments were integrated and consistent with and complement each other when a resident sustained a fall.

Rationale and Summary:
A Personal Support Worker (PSW) transferred a resident, who sustained a fall. The PSW did not notify the registered staff and requested assistance from another PSW to transfer the resident back to bed. The resident was not assessed prior to the transfer. Later in the shift, the Registered Practical Nurse (RPN) noticed the resident had a bruise on their face, prompting further assessment.

The DOC indicated the PSW did not collaborate with the registered staff when they failed to report the fall incident to them.

Failure of the staff involved in the different aspects of care of the resident to collaborate with each other in the assessment could result in a delay in treatment, an inability to monitor changes to a resident's health condition, or inaccurate documentation.

Sources: Interviews with the home's staff and management, review of resident's clinical records, and the home's investigation notes.

WRITTEN NOTIFICATION: Plan of Care

NC #004 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 the care set out in the plan of care was provided to the resident as specified in the plan.

Rationale and Summary:
The resident's care plan indicated an intervention should have been in place when in bed.

The resident was observed in bed without the intervention. The RPN acknowledged that the home did not follow the instructions as specified in the care plan.

There was risk that care provided to the resident may be delayed due to the lack of intervention in place.

Sources: Observation of resident, review of the resident's care plan, and interviews with Activation, PSW, and RPN.

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to comply with immediately reporting suspected abuse of a resident as per their policy.

Rationale and Summary:
The home policy titled "Zero Tolerance for Abuse and Neglect Policy (Ontario)," stated any staff member or person who becomes aware of and/or has reasonable grounds to suspect abuse or neglect of a resident must immediately report that suspicion and information upon which it is based to the Administrator of the home or, if unavailable, to the most senior supervisor on shift at that time.

The PSW confirmed witnessing another PSW hitting a resident in the face. The PSW acknowledged reporting the incident during the investigation interview.

The DOC confirmed the PSW did not report immediately as per the licensee's policy.

Failure to report an incident of physical abuse immediately could delay the implementation of safety measures to protect the resident from future abuse.

Sources: Zero Tolerance for Abuse and Neglect Policy, review of home's investigation notes, interviews with PSWs and DOC.

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that physical abuse towards the resident had occurred or may occur immediately report the suspicion and the information upon which it was based to the Director.

Rationale and Summary:
The investigation notes stated, a PSW reported an allegation of physical abuse toward a resident to the DOC..

The after-hours reporting system was contacted by the home the following day. A CI was submitted late to the Director related to physical abuse.

The home's failure to report to the Director immediately after becoming aware of allegations of abuse/neglect for the resident may have delayed the Director's ability to respond to the incident in a timely manner.

Sources: CI 2582-000004-24, review of home's investigation notes, and interview with PSW.

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

Rational and Summary:
A resident was found by registered staff with a bruise on the face. The home's investigation revealed that the resident had sustained a fall while under the care of a PSW when the staff transferred the resident. The resident's care plan stated the resident required two person assistance for transfers, however the staff transferred the resident independently.

The DOC indicated that the PSW should have transferred the resident with the assistance of another staff member and acknowledged the staff did not use safe transferring techniques when transferring the resident.

Failure to ensure staff utilized safe transferring and positioning techniques resulted in injury to the resident.

Sources: Interviews with the home's staff and management, review of resident's clinical record, and the home's investigation notes.

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee has failed to ensure that the appropriate police service was immediately notified of the alleged physical abuse towards the resident.

Rationale and Summary:
A Critical Incident Report was submitted to the Ministry of Long-Term Care regarding an allegation of staff to resident physical abuse. There was no record that the police services were contacted.

The DOC confirmed the police were not called at the time of the reported incident.

Failing to immediately notify the police of alleged incidents of abuse placed residents at risk of harm.

Sources: CI 2582-000004-24, review of resident's clinical record, and interview with DOC.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act using the CI system.

Rational and Summary:
The home was declared a confirmed Coronavirus disease (COVID-19) outbreak. A CI was submitted to the Director related to the confirmed COVID-19 outbreak. The IPAC Lead was aware that that confirmed COVID-19 outbreak was required to be reported immediately and confirmed that the Director was not notified immediately.

Failure of the home to immediately inform the Director may have delayed the Director's ability to respond to the incident in a timely manner.

Source: CI 2582-000013-24, interview with IPAC Lead, email correspondence from the home and public health.