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 # / Registre no	Type of Inspection / Genre d'inspection
Feb 17, 2017	2017_486653_0002	001073-17	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

ROMELA VILLASPIR (653), SHIHANA RUMZI (604)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 16, 17, 18, 19, 20, and 23, 2017.

During the course of the inspection, the inspector(s) toured the home, conducted observations of residents and care provided by staff, reviewed residents' health records, staff schedule, and relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with the residents, Substitute Decision-Makers (SDMs), Presidents of Residents' Council, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Interim Environmental Services Manager (iESM), Registered Dietitian (RD), Director of Care (DOC), and the Administrator.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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	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 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 the 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.

On an identified date, at an identified time, inspector #604 was conducting the home’s initial tour on the fourth floor. The inspector observed a medication cart located outside the nursing station and the computer screen on the medication cart was left open. Nursing staff were not observed in the area except for a Personal Support Worker (PSW) who was serving snack in the dining room across from the nursing station. Resident #001 's Point Click Care (PCC) progress notes were left open on the screen displaying information such as the resident’s vital signs, medications and health status.

An interview with RPN #100 confirmed that resident #001's Personal Health Information (PHI) was visible to anyone in the halls as the screen was left open. The RPN stated that the home’s expectation was for staff to lock the computer screen when not in use. When the inspector asked if the nurse protected resident #001's PHI, RPN #100 stated he/she did not protect the resident's PHI.

An interview with the home’s Director of Care (DOC) indicated staff have to log off the PCC screen when not in use to protect resident’s privacy. The DOC stated he/she was aware of the situation on the fourth floor and staff did not protect the resident’s PHI. [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 the following right of the residents is fully respected and promoted:
-Every resident has the 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, to be implemented voluntarily.

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. (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 the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed.

During stage one of the Resident Quality Inspection (RQI), resident #004 triggered for a new skin impairment.

A review of an identified assessment on an identified date, indicated that the resident internally acquired an identified skin impairment. The resident was to be treated with an identified medication twice per day.

A review of resident #004’s written plan of care on an identified date, revealed it was the last date the document had been reviewed, as there was no succeeding written plan of care found in the history portion on PCC. The written plan of care on that identified date, did not identify resident #004 had an identified skin impairment.

An interview with RPN #102 stated the resident’s plan of care was to be updated when there were changes in skin integrity and when there were new problems or changes in the resident’s needs which had not been previously identified. The RPN also stated that it was the responsibility of the nurse to update the plan of care. The RPN further stated resident #004’s written plan of care was last updated on an identified date, and it did not indicate resident #004’s identified skin impairment. The RPN further indicated that if the written plan of care was not updated, the staff would not know that resident #004 had an identified skin impairment.

An interview with the home’s DOC identified staff were to update the written plan of care when there is a change with care and when an identified assessment was carried out. The DOC also stated it was the responsibility of the nurses on the floor to update the written plan of care. After the DOC reviewed resident #004’s written plan of care, he/she confirmed that it was last updated on an identified date, and that it failed to show that resident #004 had an identified skin impairment. [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 resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change, to be implemented voluntarily.

Issued on this 17th day of February, 2017

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

Original report signed by the inspector.