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
May 28, 2018	2018_493652_0007	006698-18	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

NATALIE MOLIN (652), ARIEL JONES (566), NITAL SHETH (500)

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): April 5, 6, 9, 10, 11, 12, 13, 17, 18, 19, and 20, 2018.

The following Critical Incident System (CIS) inspections were conducted concurrently with the RQI: 005517-17; CIS #2582-000003-17 (related to plan of care); # 024886-17; CIS #2582-000014-17 (related to Skin and Wound Care); and #007378-18; CIS #25282-000004-18 (related to Falls Management).

The following follow up inspection was conducted concurrently with the RQI: Log #025048-17(related to doors leading to non-residential areas); #025049-17 (related to heights measured and recorded annually).

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Environmental Service Manager (ESM), Food Service Manager (FSM), Registered Dietitian (RD), Dietary Aide, Activation Director, Activation Aide, Housekeeping Aide, receptionist, Medical Director, ICU physician. Responsive Behaviour Support lead, Skin and Wound Care lead, registered staff, personal support workers (PSW), Residents' Council president and Family Council representative, residents, substitute decision makers (SDMs).

During the course of the inspection, the inspector(s) conducted a tour of the resident care areas, reviewed residents' health care records, follow-up orders documentation and actions implemented by the home, mandatory training records, home policies and procedures, for the Fall Management Program, Skin and Wound Program, Continence Care Program, Smoking, observed resident rooms, observed resident common areas, and observed the delivery of resident care and services, including resident–staff interactions, observed residents' dining experiences, observed infection control practices, observed the administration of medications and review of the licensee's medication incidents and adverse drug reactions processes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 68. (2)	CO #002	2017_644507_0012	500
O.Reg 79/10 s. 9. (1)	CO #001	2017_644507_0012	566

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. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The Licensee failed to ensure the plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 19. Safety risks.

A Critical incident system report was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date and time in regards to an identified incident with resident #010 who was subsequently transferred to the hospital and treated for an injury.

Resident #010 was observed lying in their bed on two identified dates. Resident was not observed engaged in an identified activity during the inspection.

Record review of resident #010's progress notes on an identified date, indicated receptionist #132 called RN #120 to advise that resident #010 was engaged in an identified activity and had an incident. Resident #010 sustained injury to identified body parts.

Record review of resident #010's written plan of care on an identified date, indicated resident #010 is at risk of falling, required the use of a mobility aid for far distances, and preferred not to use the mobility aid when engaged in the identified activity, and could exhibit verbal aggression if encouraged to do so. This written plan of care does not address any safety risk to resident #010 engagement in the identified activity. There is no evidence to support an identified assessment had been completed for resident #010 until an identified date, one day after resident #010's identified incident.

Interview with RN #120 acknowledge an identified assessment had not been completed for resident #010 until an identified date, RN #120 stated that the identified assessment was not endorsed nor was the expectations of when and how often the identified assessment should be completed.

Interview with RN/Building Supervisor acknowledge that resident #010 was identified as engaging in this activity since their admission on an identified date, and the expectation is that an identified assessment should have been completed for resident #010 to determine the safety risk to resident #010.

Interview with the DOC stated an identified assessment should have been completed for resident #010 prior to an identified date. [s. 26. (3) 19.]

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. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin

assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

A Critical incident system report was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date and time related to an incident which resulted in injury and required a transfer to hospital. Resident #011 was admitted to an identified hospital on an identified date, and was treated for an injury. Resident #011 passed away 20 days later.

Record review of resident #011's progress notes on an identified date indicated the DOC received a call from an Inspector from the Ministry of Health and Long Term Care (MOHLTC) about an incident report that was submitted on an identified date. This note indicated as per Inspector's report that resident #011 was transferred to hospital because of an identified injury to an identified body part and was admitted with an identified diagnosis. The home has no record about the identified injury and according to nurses' documentation, resident #011 had an identified skin impairment to identified body parts. The home had learned of the identified injury from the Ministry. This note indicated the DOC had provided to the ministry's inspector the history of the skin impairment on resident #011's identified body parts from an identified date up until resident #011 was transferred to the hospital. The DOC phoned the hospital and when asked about the identified injury, the nurse indicated that resident #011 had an identified injury and the ministry was notified.

Record review of resident #011's progress notes on an identified date indicated RN #120 followed up with the DOC on the concerns of resident #011's non-compliance with care and treatments and they are unable to do an identified assessment weekly or regularly. The behavioral support team leader was to be informed and follow-up again about these matters as resident #011's identified condition on their identified body part was deteriorating as previously documented.

Record review of resident #011's progress notes on an identified date, indicates the following: the medical director #130 assessed resident #011 and resident #011 was found to display identified signs and symptoms and patient sent to hospital.

Record review of resident #011's progress notes on an identified date, indicated resident #011 had impairment to an identified body parts and was experiencing identified signs and symptoms. The area was cleansed with identified treatment as ordered. This note indicated the medical doctor (MD) to re-assess resident #011 in the morning as the

identified impairment on a specified body part was deteriorating. This note also indicated resident #011 has to comply with specified practices as resident #011 did not have an identified activity in months.

Record review of resident #011's progress on an identified date, indicated resident #011 still had identified impairment to specified body parts. The area was cleansed with an identified treatment order and resident encouraged to comply with care for better healing.

Record review of resident #011's progress notes on an identified date, indicated RN #120 re-assessed resident #011's identified body parts. This note also indicated signs and symptoms in resident #011's identified body parts. Redness on the identified body part could cause breakdown because of poor maintenance of resident #011's identified activity of daily living (ADL) as resident has not participate in an identified activity for months. An identified treatment was applied to resident #011's identified body parts for protection and potential impairment of an identified body part. RN #120 asked the DOC to speak with resident #011 to encourage resident #011 to participate in an identified activity as no matter how the resident's identified body part is treated with an identified product, if resident #011 does not accept the identified activity resident #011's impairment to an identified body part will not be resolved or improved.

Record review of resident #011's identified assessment on an identified date, indicated resident #011 had an impairment to an identified body part. There is no evidence to support that and interdisciplinary assessment was conducted for resident #011 which included the Registered Dietitian.

Record review of the home's identified policy revised April 2017, indicated the Registered Dietitian is responsible for assessing the adequacy of oral, enteral intake and assessing each resident who exhibits impairment to an identified body part. This policy also mentions the attending physician is responsible for assessing residents with altered integrity to an identified body part and refer them to the Physiotherapist, Occupational Therapist, Dietitian, or an identified specialist as necessary.

Record review of resident #011's last written plan of care on an identified date, indicated resident #011 had potential risk for impairment to an identified body part related to long period of sitting on an identified equipment, and identified concerns related to refusing care and treatment and resident #011 had impairment to identified body parts. This written plan of care also directed staff to initiate a referral to the Registered Dietitian and under the Registered Dietitian's guidance implement, reinforce, monitor and document

appropriate dietary regimen. There is no evidence in resident #011's healthcare records that a dietary referral had been initiated for resident #011 to address their impairment to an identified body part needs.

Interview with PSW #131 stated on an identified date resident #011 had impairment to identified body parts, RN #120 was called to assess and took care of the resident's identified body part. During this interview PSW #131 stated on an identified date, right after shift report that they were trying to put resident #011 on an identified product and resident #011 could not stand up and while trying to put resident #011 to bed the resident's identified body part was of a specified colour and temperature. The resident's identified body part was identified as a specific colour so PSW #131 called RN #120 who advised PSW #131 that MD #130 was coming and would give resident #011 a better treatment.

Interview with RN #120 indicated, when resident #011 was sent out to the hospital on an identified date, PSW #131 was giving morning care and called RN #120 to see resident #011 because the resident was not themselves. RN #120 mentioned resident #011 was active, alert, and an identified vital sign was low so the building supervisor was called to further assess and because MD# 130 was coming they monitored resident #011 until the doctor assessed the resident and they were sent out to the hospital right away. During this interview RN #120 revealed that on an identified date, resident #011 had impairment to identified body parts but no injury. RN #120 also mentioned the identfied impairment could be as a result of resident #011 sitting on the chair and the identified product, because resident #011 spent all their time sitting outside. RN #120 acknowledged an identified assessment was not completed for resident #011 to address their impairment to an identified body, instead an identified note was completed.

Interview with RN/Building Supervisor/ Skin and Wound Coordinator #129 stated that resident #011 is at risk for impairment to an identified body part skin , and an identified assessment should have been completed to reassess resident #011's identified body part.

Interview with the DOC acknowledge the expectation is that an identified assessment should have been completed for resident #011. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds: been assessed by a registered dietitian who is a member of the staff of the home, and had any changes made

to the plan of care related to nutrition and hydration been implemented.

A Critical incident system report was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date related to incident with injury/hospital transfer/significant change in status. Resident #011 was admitted to an identified hospital on an identified date, and was treated for altered skin integrity to identified body parts. Resident #011 passed away 20 days later.

Resident #011 had altered skin integrity to an identified body part on four identified dates, and the record review and staff interviews confirmed no RD assessment was conducted.

Record review of the home's identified policy revised April 2017, indicated the Registered Dietitian is responsible for assessing the adequacy of oral, enteral intake and assessing each resident who exhibits impairment to an identified body part. This policy also mentions the attending physician is responsible for assessing residents with impairment to the identified body part and to refer them to the Physiotherapist, Occupational Therapist, Dietitian, or an identified specialist as necessary.

Interview with the DOC stated the expectation is that a dietary referral should have been completed for resident #011. [s. 50. (2) (b) (iii)]

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 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment; to ensure that the resident is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the plan of care related to nutrition and hydration implemented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent received an assessment that: includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

During stage one of the RQI, resident #006 was triggered for an identified appliance use during the staff interview.

Observations of resident #006 throughout the inspection revealed they do have an identified appliance in place.

Record review of resident #006's Physician's notes-Problem Sheet on an identified date, indicated resident #006 was admitted to the nursing home with an identified appliance.

Record review of resident #006's Assessment records in Point Click Care indicated there is no supporting evidence that an identified assessment was completed for resident #006 since their admission on an identified date.

Interview with RN #120 acknowledged an identified assessment was not completed for resident #006 since their admission in 2015, and stated the expectation is that the identified assessment should have been completed.

Interview with the RN/Building Supervisor #129 stated that the identified assessment had not been completed for resident #006 since their admission on an identified date, and the expectation is that the identified assessment should have been completed.

Interview with the DOC acknowledged that resident #006 was admitted to the nursing home with the identified appliance and stated the expectation is that the identified assessment should have been completed for resident #006. [s. 51. (2) (a)]

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 who is incontinent received an assessment that: includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require, to be implemented voluntarily.

WN #4: 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 the staff and others involved in the different aspects of care of the resident collaborate with each other, 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.

The Inspector completed a mandatory task of dining room observation on April 5, 2018, at 1300 hours in the main dining room for the second seating of residents.

During dining room observation, activation aide #126 approached the Inspector and raised a concern that resident #031 likes to eat an identified food and the home is not providing it. Activation Aide #126 indicated that the concern was raised to the dietary manager several times.

Interview with resident #031's Substitute Decision Maker (SDM) stated that the resident would like to have the identified food when it is on the menu.

A review of the home's diet sheet, indicated that resident #031 was on an identified diet, and staff to provide an identified food to the resident.

Interview with Dietary Aide #100 and FSM stated that the home's therapeutic menu does not indicate to provide the identified food to residents receiving an identified texture, therefore, Dietary Aide #100 could not serve the identified food to resident #031.

Interview with RD stated that the resident can have the identified food however staff who is assisting the resident is required to remove the skin of identified food and mash it up for the resident. RD indicated that the diet sheet needed to be revised to reflect this change in the diet, in regards to the resident's food preference.

Interview with the DOC stated that the resident should have been fed as per their needs. [s. 6. (4) (a)]

2. 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 change or care set out in the plan is no longer necessary.

1) During stage one of the Resident Quality Inspection (RQI) resident #004 was triggered for an identified appliance during the staff interview.

Observations of resident #004 during stage one of the inspection and throughout the inspection revealed they do not have the identified appliance in place.

Record review of resident #004's identified assessment upon admission on an identified

date, revealed they had an identified diagnosis and used an identified product.

Record review of resident #004's progress notes on an identified date, indicated they returned from hospital with an identified procedure and identified appliance in place. An object was removed from the identified body part, but the physician could not reach the object in the identified body part, so these were left, resident #004 had a difficult procedure and experienced identified symptoms post-operation. Progress notes on an identified date, indicated resident #004 had the an identified object removed and an identified appliance was put in place. The progress notes indicated the staff were monitoring resident #004's identified output while the identified appliance was in site.

A progress note on an identified date, indicated resident #004 had a follow-up appointment with an identified specialist and as per resident #004's spouse resident #004 does not like to have the identified appliance and the identified specialist did not want to make any decision about removing the identified appliance and the attending physician at the nursing home was aware and wanted to wait for the report and follow-up.

A progress note on an identified date, indicated the medical doctor assessed resident #004 and ordered to remove resident #004's identified appliance.

A progress note on an identified date, indicated the medical doctor spoke to resident #004 and family and they realized the risk for an identified diagnosis and requested removal of resident #004's identified appliance. A progress note on this same date, indicated resident #004's identified appliance was removed, and resident denied having any symptoms and tolerated the procedure well.

Record review of resident #004's Physician's Order Form on an identified date, indicated an order to remove the identified appliance as per family and resident #004's request and an identified procedure to be carried out as needed (PRN).

Record review of resident #004's health care records and assessments indicated there is no evidence to support they were 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 such as when the identified appliance was discontinued on an identified date.

Record review of the Heritage Nursing Home identified Policy Revised date: November

2017, revealed that for residents who have been identified with an identified diagnosis staff are to assess the resident quarterly or if there is a change in the resident's condition that affects the resident's identified diagnosis.

Record review of resident #004's written care plan initiated on an identified date, revealed resident #004 has an identified diagnosis. The plan also mentions resident #004 wear an identified product, there is no mention of resident #004's identified appliance needs which had been in place on an identified date.

Interview with Registered Practical Nurse (RPN) #105 stated the expectation is that an identified assessment should have been completed for resident #004 when the identified appliance was initiated on an identified date and one done in an identified date, when resident #004's appliance was discontinued. RPN #105 also acknowledged that resident #004's written plan of care in June 2017, should have reflected their appliance care needs.

Interview with the Director of Care (DOC) acknowledged that an identified assessment should have been completed for resident #004 when the identified appliance was discontinued on an identified date, and that resident #004's written plan of care for an identified date, should address the resident's appliance care needs. [s. 6. (10) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee shall ensure that the home has and that the staff of the home comply with, a cleaning schedule for the food production, servery and dishwashing areas.

Observation on April 19, 2018, at 1200 hours in the kitchen revealed that the dishwashing area had dried food particles on the ceiling, spots of water leakage on the ceiling, wall behind the stove greasy with dust and dirt and, the walls at the pot and pan sink station was stained a blackish-green colour that looked like algae.

A review of the home's cleaning schedule indicated that shift #6 assigned duties for cleaning included dish machine area, oven area, garbage bin areas and walls. The schedule was not signed (initialed) by staff who performed the duties on April 6, 7, 8, 9, 12, 14, and 16, 2018. The supervisor also did not sign (initial) the schedule for the above mentioned dates in the check and comment section.

Interview with Dietary Aide #127 stated that she would perform the duties but was not required to initial the schedule. While the Inspector asked, if they are able to perform their cleaning duties in their shift, they indicated that they did not clean walls behind the stove and behind the pot and pan sink areas because it should have been cleaned during deep cleaning.

Interview with FSM stated that the home had kitchen deep cleaning performed on April 10, 2018, however the above mentioned un-cleaned areas were not cleaned during this cleaning. FSM indicated that the staff assigned to cleaning duties are required to initial on the schedule and that the FSM is required to initial the schedule after checking the cleaning assigned work is performed by the staff for the above mentioned dates. FSM also confirmed that they and staff did not initial the cleaning schedule posted on the wall. During this interview, FSM also confirmed that the above mentioned identified areas should be cleaned. [s. 72. (7) (c)]

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

Issued on this 28th day of June, 2018

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NATALIE MOLIN (652), ARIEL JONES (566), NITAL SHETH (500)
Inspection No. / No de l'inspection :	2018_493652_0007
Log No. / No de registre :	006698-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 28, 2018
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. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order / Ordre :

The Licensee must be compliant with s. 26 (3) (19) of the LTCHA.
Specifically the licensee must:
Ensure that resident #010 and any other resident who is identified as engaging in the identified activity receives a risk assessment. The written plan of care will document the outcome of the risk assessment and the care needs of the resident as it relates to the resident engagement in the identified activity.

Grounds / Motifs :

1. The Licensee failed to ensure the plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 19. Safety risks.

A Critical incident system report was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date and time in regards to an identified incident with resident #010 who was subsequently transferred to the hospital and treated for an injury.

Resident #010 was observed lying in their bed on two identified dates. Resident was not observed engaged in an identified activity during the inspection.

Record review of resident #010's progress notes on an identified date, indicated receptionist #132 called RN #120 to advise that resident #010 was engaged in an identified activity and had an incident. Resident #010 sustained injury to identified body parts.

Record review of resident #010's written plan of care on an identified date,indicate resident #010 is at risk of falling, required the use of a mobility aid for far distances, and preferred not to use the mobility aid when engaged in the identified activity, and could exhibit verbal aggression if encouraged to do so. This written plan of care does not address any safety risk to resident #010 engagement in the identified activity. There is no evidence to support an identified assessment had been completed for resident #010 until an identified date, one day after resident #010's identified incident.

Interview with RN #120 acknowledge an identified assessment had not been completed for resident #010 until an identified date, RN #120 stated that the identified assessment was not endorsed nor was the expectations of when and

how often the identified assessment should be completed.

Interview with RN/Building Supervisor acknowledge that resident #010 was identified as engaging in this activity since their admission on an identified date, and the expectation is that an identified assessment should have been completed for resident #010 to determine the safety risk to resident #010.

Interview with the DOC stated an identified assessment should have been completed for resident #010 prior to an identified date. [s. 26. (3) 19.]

The severity of this issue was determined to be a level 3 as resident #010 experienced actual harm. The scope of the issue was a level 1 as it relates to resident #010. The home had a level 2 compliance history as they had unrelated non-compliance
(652)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 28, 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 28th day of May, 2018

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 : Natalie Molin

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