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
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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
Nov 7, 2018	2018_530726_0006	027247-18	Follow up

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

REBECCA LEUNG (726)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): October 11, 12, 15 and 16, 2018

The following intake was completed during this follow up inspection:
Log #027247-18: CO#001 was related to safety risks

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Practical Nurses (RPN), Behaviour Support Team Lead, Personal Support Workers (PSW), Occupational Therapist (OT), Receptionist, staff from Resident and Family Services, residents, family member and substitute decision-maker (SDM).

The inspector conducted observations of residents and record reviews of residents.

The following Inspection Protocols were used during this inspection:
Personal Support Services

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)**

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. 26. (3)	CO #001	2018_493652_0007	726

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. (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. 2007, c. 8, s. 6 (7).

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 collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complement each other.

A follow up inspection for a compliance order from an identified inspection report was completed.

Resident #002 was selected for inspection as they were identified as one of the residents engaged in an identified activity in the home.

Review of progress note for an identified date, indicated that the OT received a referral from the nursing team to assess resident #002's therapeutic device for not maintaining the specific therapeutic function. OT #104's assessment indicated some damages were found on resident #002's therapeutic device.

In an interview, OT #104 indicated that during the discussion with resident #002 on an identified date, resident #002 stated that they were not aware of the damages on their therapeutic device. OT #104 confirmed that after completing the assessment for resident #002 on an identified date, they spoke with the nursing team regarding the damages found in resident #002's therapeutic device due to unsafe performance of an identified activity.

Review of OT #104's progress notes for a number of identified dates, indicated that OT #104 had documented repeatedly regarding the issues with unsafe performance of an identified activity related to resident #002. OT #104 indicated a replacement for the therapeutic device would be offered to resident #002 as the current therapeutic device was damaged beyond repair by the identified activity.

Review of resident #002's last identified assessment completed by RPN #103 on an identified date, did not indicate the issues with unsafe performance of an identified activity due to damages found on resident #002's therapeutic device as indicated in OT #104's progress note dated an identified date.

In an interview, RPN #103 stated that they completed the identified assessment for resident #002 on an identified date, for the regular quarterly assessment, as they were not aware that the regular quarterly identified assessment had already been completed by another registered staff on an identified date. RPN #103 confirmed that when they were completing the identified assessment for resident #002 on an identified date, they did not review OT #104's progress note dated on an identified date, and they were not aware that OT #104 had identified issues related to unsafe performance of an identified activity for resident #002. RPN #103 further confirmed that they were not aware that OT #104 had documented repeatedly on the issues related to unsafe performance of an identified activity for resident #002 in the progress notes dated a number of identified dates.

In an interview, the Director of Care #106 confirmed that the registered staff should have repeated the identified assessment for resident #002 to address the issues related to unsafe performance of the identified activity as indicated in OT #104's assessments. [s. 6. (4) (a)]

2. 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.

As a result of non-compliance related to resident #002, resident #003 was selected to increase the sample. Resident #003 was identified as one of the residents engaged in an identified activity in the home.

Review of resident #003's identified assessment completed on an identified date, indicated specific functional issues and recommendations were provided for safe

performance of an identified activity including close supervision and the use of a specific safety device while resident #003 was engaging in the identified activity. In addition, resident #003 would only engage in the identified activity when their family was visiting.

Review of resident #003's care plan indicated that the above mentioned recommendations for safe performance of the identified activity were included in the interventions under the focus for the identified activity.

On an identified date and time, the inspector observed resident #003 was sitting in their mobility device accompanied by their family in an identified location. Resident #003 and their family were engaging in the identified activity at the same time. Inspector observed resident #003 did not use the specific safety device while they were engaging in the identified activity.

In an interview, receptionist #105 stated that they were not aware that resident #003 was supposed to obtain the specific safety device from them before engaging in the identified activity with the family.

In an interview, resident #003's family confirmed that since resident #003 was admitted to the home on an identified date, the home had not provided resident #003 with the specific safety device before resident #003 engaged in the identified activity. Resident #003's family stated that the staff had just approached them to discuss the specific safety device prior to the interview with the inspector.

In an interview, RPN #108 stated that they were not aware of the intervention written in resident #003's care plan that the specific safety device would be provided to resident #003 to prevent injury during the identified activity.

In an interview, the DOC #106 acknowledged that the registered staff should have informed and instructed the resident and family regarding the need and proper use of the specific safety device for resident #003 at the time when the plan of care was developed and implemented. [s. 6. (7)]

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 in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, and
- to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 16th day of November, 2018

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

Original report signed by the inspector.