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
Aug 16, 2021	2021_631210_0020	010662-21	Critical Incident System

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

SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 4, 5, 9, 10, and 11, 2021.

The folowng Critical Incident System (CIS) reports were inspected:
-One intake related to unexpected death

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Physician, Dietary Aid (DA), Registered Dietitian (RD), Food Service Supervisor (FSS), Registered Nurse (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), maintenance technician and residents.

During the course of the inspection, the inspector conducted observations of the home, including resident home areas, staff to resident interactions, reviewed internal investigation notes, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Dining Observation
Hospitalization and Change in Condition
Infection Prevention and Control
Personal Support Services
Reporting and Complaints
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **5 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	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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

Resident #001's diet was changed to a different food texture and fluid consistency on a specified date, due to change in health status. They were consuming a specific food before the diet change and it was not deleted from the care plan after the diet change.

On a specified date and time the resident had a medical emergency and subsequently passed away. The First aid attempts by staff and paramedics were unsuccessful. The resident was served a specific food, the same as they were taking before the diet change.

The home’s therapeutic diet spreadsheet indicated that the above mentioned specific food was not applicable to residents who received a different texture. The specific food was not supposed to be served to residents who required modified fluids, because of the increased risk. The residents had to be assessed if it was safe for them to take the specific food and to be documented in their care plan. Resident #001 received the specific food and they ate around 25% of their meal. The staff assumed that it was safe for resident #001 to eat the specific food because they had the same ingredient in their main course plate.

The written plan of care for resident #001 did not indicate that the resident was not to be served the specific food at meals.

Sources: resident #001's care plan, home’s therapeutic diet list, interview with Registered Dietitian (RD), Food Service Supervisor (FSS), PSW and and Dietary Aid (DA). [s. 6. (1) (c)]

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 plan of care set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to ensure that supplies, equipment and devices were readily available to meet the nursing and personal care needs of the resident.

Resident #001 had a medical emergency on a specified date and time which required emergency response at the home. Several registered staff arrived at the scene of the emergency and initiated a first aid procedure. Staff attempted to perform medical intervention however the equipment was not readily available.

Sources: review of audit/check list for availability and functionality of the specific machine on every unit, interview with registered staff and the DOC. [s. 44.]

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 supplies, equipment and devices are readily available to meet the nursing and personal care needs of the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home.

The home was not able to present to the inspector that the temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home.

Source: review of temperature measurement logs, interview with the DOC and maintenance technician. [s. 21. (2) 1.]

2. The licensee has failed to ensure that the temperature was measured and documented in writing in one resident common area on every floor of the home.

The DOC and the maintenance technician indicated that the temperature was not measured and documented in writing in one resident common area on every floor of the home, which may include a lounge, dining area, or corridor. The home measured and documented the temperature in only one common area, the dining room on first floor, but not other floors.

Source: review of temperature measurement logs, interview with the DOC and maintenance technician. [s. 21. (2) 2.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (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 (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances, about an unexpected or sudden death, including a death resulting from an accident in the home, followed by the report required under subsection (4).

Resident #001 passed away on a specified date and time related to medical emergency. The DOC indicated that the expectation was the after-hours line to be contacted to report the resident's unexpected death.

A Critical Incident System (CIS) report was not submitted immediately to the Ministry of Long Term Care (MLTC) for the unexpected death on the day of the incident, but two days later.

Sources: review of CIS report, interview with the DOC. [s. 107. (1) 2.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

Observation during the inspection period indicated staff on one identified unit, came out from a resident room wearing gloves not being disposed in the resident's room.

The staff did not follow the infection prevention and control best practice to perform hand hygiene when leaving the point of care after providing personal care to residents. The two staff members did not remove their gloves and use alcohol based hand rub when leaving the resident care environment.

Sources: observation, interview with the DOC. [s. 229. (4)]

Issued on this 25th day of August, 2021

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

Original report signed by the inspector.