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

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Original Public Report

Report Issue Date: February 6, 2023	
Inspection Number: 2023-1096-0002	
Inspection Type: Critical Incident System	
Licensee: Heritage Nursing Homes Inc.	
Long Term Care Home and City: The Heritage Nursing Home, Toronto	
Lead Inspector Kim Lee (741072)	**Inspector Digital Signature** Kim Lee Digitally signed by Kim Lee Date: 2023.02.08 11:26:55 -05'00'
Additional Inspector(s) Goldie Acai (741521)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 24-27, 2023

The following intake(s) were inspected:
- Intake: #00008631 (CIS: 2582-000006-22) – related to falls;
- Intake: #00008786 (CIS: 2582-000007-22) – related to improper transferring.

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

Falls Prevention and Management
Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22 102 (7) (11)

The licensee failed to ensure that the Infection Prevention and Control (IPAC) Lead carried out their responsibilities related to the hand hygiene program.

The IPAC Lead failed to ensure access to effective hand hygiene agents at point-of-care in accordance with the "Infection Prevention and Control Standard for Long Term Care Homes April 2022" (IPAC Standard). Specifically, the IPAC Lead did not ensure that the hand hygiene program discontinued all expired 70 to 90 percent alcohol-based hand rub (ABHR) products as required by Additional Requirement 10.1 under the IPAC Standard.

A number of expired ABHR products were observed to be expired throughout the LTCH including residential areas. A housekeeper stated that they were required to replace expired ABHR and did not know why the expired ABHR products were in circulation. The housekeeper stated they would replace the expired product immediately of a specific home area. When brought to the attention of the Director of Care (DOC), they stated that the LTCH would replace the expired ABHR throughout the LTCH immediately.

The IPAC Lead stated that as part of routine IPAC self-audits, the IPAC Lead would check the expiry dates of ABHR products used by the LTCH. The most recent IPAC self-audit that same month indicated that ABHR products were not expired. The IPAC Lead did not know why there were expired ABHR products circulating in the LTCH.

The risk to residents was low as the home was not currently or recently in outbreak, and all identified expired ABHR products throughout the LTCH were replaced immediately.

Sources: Observations of expired ABHR, interviews with staff, LTCH's most recent IPAC self-audit.

Date Remedy Implemented: January 27, 2023
[741072]

WRITTEN NOTIFICATION: Binding on licensees

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure they carried out every operational or policy directive that applies to the long-term care home (LTCH).

Rationale and Summary

The "Minister's Directive: COVID-19 response measures for long-term care homes" required all homes to follow the "COVID-19 Guidance document for long-term care homes in Ontario."

The guidance document required homes to complete IPAC audits every two weeks unless in outbreak, which included Public Health Ontario's (PHO's) "COVID-19: Self-Assessment Audit Tool for Long-term Care Homes and Retirement Homes."

The IPAC Lead stated that they completed COVID self-audits biweekly, and weekly when in outbreak. Two IPAC audits were completed 3 weeks apart. In addition, the LTCH's last IPAC self-audit was over 2 weeks prior.

The home was not currently or recently in outbreak during the period of IPAC self-audit lapse and failure to conduct the audits at the required interval put the residents at low risk.

Sources: Record review of Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022 and COVID-19 Guidance document for long-term care homes in Ontario, Version 9 – January 18, 2023, LTCH's IPAC self-audits, LTCH's IPAC Manual, interview with IPAC Lead.
[741072]

WRITTEN NOTIFICATION: Compliance with manufacturers' instructions

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 26

The licensee has failed to ensure COVID screening staff used testing supplies in accordance with the manufacturer's instructions.

Rationale and Summary

Multiple COVID testing staff on multiple days were observed processing COVID tests. In those instances, staff did not allow the swab to sit in the buffer solution for two minutes prior to adding it to the test device. The product insert stated that the swab was to stand in the buffer solution for two minutes following specimen collection.

A COVID Tester stated that the LTCH had recently changed COVID test manufacturers. The IPAC Lead stated that previous COVID test kits did not require the swab to sit in the buffer solution for two minutes. The IPAC Lead stated that the test kit might have been recently replaced and they were not aware of the change.

At the time of the observations, the home was not currently or recently in outbreak however The IPAC Lead acknowledged that failing to follow the manufacturer's direction may have led to false negative results putting the LTCH at risk for COVID.

Sources: Observation of testing processes, interviews with staff, record review of COVID test product insert.
[741072]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 40

The licensee has failed to ensure that a Personal Support Worker (PSW) used safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary

A PSW stated that on a given day, they had transferred a resident contrary to the plan of care and without the assistance of another staff member. The PSW stated that they did not check the plan of care before attempting to transfer the resident because they felt rushed. The PSW stated that at the time of incident, they were very nervous because they were new.

At the time of the incident, the resident's plan of care indicated that the resident was only to be transferred by a specific method. Further, the plan of care explicitly stated that the resident could not be transferred by the method that the PSW had employed.

The DOC stated that the PSW did not transfer the resident according to the plan of care and against the LTCH's policy where all transfers must be conducted with another staff member present.

As a result of the improper transfer method, the resident sustained a transfer-related injury. The PSW was disciplined and completed re-education activities. The PSW was remorseful and no further incidents of a similar nature involving PSW had occurred since.

Sources: Interview with staff, record review of resident plan of care and LTCH Transferring policy. [741072]

WRITTEN NOTIFICATION: Falls prevention and management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 54 (1)

The licensee has failed to ensure the fall prevention and management strategies to mitigate falls for two residents were implemented and complied with.

In accordance with O. Reg 246/22 s. 11 (1) b, the licensee is required to ensure that residents who are at moderate or high risk for falls are identified as such.

Rationale and Summary

Specifically, the staff did not comply with the Resident Care Manual, Fall Management Program, January 2022. The policy required that a specific fall intervention was to be in place to quickly identify residents at high or moderate risk for falls.

Two residents required specific fall interventions to be in place in their rooms. Through observations of the two resident rooms, it was determined that the interventions were absent.

Two staff denied having any program in the home that would quickly identify a resident who is at high or moderate risk for falls. Instead, staff can view specific areas in the LTCH's eMAR system. Staff members indicated that staff are expected to familiarize themselves with the care plan for the residents regarding fall risk status. In addition, it is verbally communicated to new hires during the onboarding and training process.

A resident had a number of falls in the past six months. There was risk identified when the resident who was at risk for falls was not identified by the methods described in the home's falls prevention and

management program.

Sources: Observations, interviews with staff, record review Fall Management program, January 2022. [741521]