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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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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
Nov 28, 2014	2014_267528_0035	H-000390-14	Complaint

Licensee/Titulaire de permis

HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE STONEY CREEK ON L8J 2J3

Long-Term Care Home/Foyer de soins de longue durée

HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE STONEY CREEK ON L8J 2J3

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

CYNTHIA DITOMASSO (528)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 6 and 7, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Dietary Manager, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), restorative staff, dietary aides, physiotherapy assistants, housekeeping, residents and families related to Complaint Log # H-000390-14

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

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

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 failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and other who provide direct care to the resident.

A) During a dinner service observation on November 6, 2014, in the first floor dining room, resident #001 was noted to receive a regular sized bowl of soup.
i. Review of the plan of care included a dietary assessment from October 2014, which outlined new interventions, including but not limited to: a large bowl of soup at supper time. The Resident Meal Service information sheet stated the resident was to receive "large bowl cream soup" at supper time. The documents the home refers to as the care plan and kardex stated the resident was to have a "large bowl of soup, especially cream soups".
ii. Interview with dietary aide serving the meal indicated that since the soup was not a cream soup he did not provide the resident with a large bowl of soup.
iii. Discussion with Food Services Manager and Administrator confirmed that the direction to dietary staff was not clear. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) During a dinner meal service observation on November 6, 2014, on the first floor dining room, resident #001 was overheard telling a co-resident that they did not get their tomato juice.
i. The plan of care for resident #001 indicated the they were at high nutritional risk and was to receive the following beverages at dinner time: 125 mililitres (ml) of chocolate

milk, tomato juice, 180 ml of water, black tea, and juice or other was to be offered.
ii. Interview with the dietary aide who was serving beverages confirmed that the resident did not receive their tomato juice as outlined on the dinner beverage list.

B) On November 6, 2014, resident #001 was observed from 10:30 hours to 1400 hours. At approximately 1330 hours, the resident requested to use the bathroom and was assisted by two staff members.
i. The plan of care for resident #001 indicated that the resident was incontinent of bladder related to impaired mobility and physiological changes. Interventions included but were not limited to incontinence program and staff were directed to remind and or assist to toilet before meals, after meals and before bed to prevent incontinent episodes.
ii. Review of Point of Care (POC) documentation from November 6, 2014, which indicated that the resident was toileted after breakfast at 9:55 hours.
iii. Interview with direct care staff confirmed that the resident was not reminded or assisted to the toilet before being assisted to the dining room for lunch as outlined in the plan of care. [s. 6. (7)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 5th day of December, 2014

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CYNTHIA DITOMASSO (528)
Inspection No. / No de l'inspection :	2014_267528_0035
Log No. / Registre no:	H-000390-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 28, 2014
Licensee / Titulaire de permis :	HERITAGE GREEN NURSING HOME 353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3
LTC Home / Foyer de SLD :	HERITAGE GREEN NURSING HOME 353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	

To HERITAGE GREEN NURSING HOME, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_214146_0005, CO #012;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall ensure the following:
i. that the plan of care sets out clear directions related to nutritional interventions; including but not limited to: specific interventions at meal and snack times as specified by the Registered Dietitian, to staff and others who provide direct care to all residents including resident #001.
ii. all dietary and applicable nursing staff are re-educated and trained on providing nutritional interventions to all residents, as ordered, during meal and snack service.

Grounds / Motifs :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and other who provide direct care to the resident.

A) During a dinner service observation on November 6, 2014, in the first floor dining room, resident #001 was noted to receive a regular sized bowl of soup.
i. Review of the plan of care included a dietary assessment from October 2014, which outlined new interventions, including but not limited to: a large bowl of soup at supper time. The Resident Meal Service information sheet stated the resident was to receive "large bowl cream soup" at supper time.
ii. Interview with dietary aide serving the meal indicated that since the soup was not a cream soup he did not provide the resident with a large bowl of soup.
iii. Discussion with Food Services Manager and Administrator confirmed that the direction to dietary staff was not clear. (528)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 12, 2014

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_214146_0005, CO #004;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care for resident #001 is provided to the resident as specified in the plan; including but not limited to: beverages at meal and snack times to be provided as specified on the beverage list, and toileting as outlined in the resident's toileting schedule.

Grounds / Motifs :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) During a dinner meal service observation on November 6, 2014, on the first floor dining room, resident #001 was overheard telling a co-resident that they did not get their tomato juice.
i. The plan of care for resident #001 indicated the they were at high nutritional risk and was to receive the following beverages at dinner time: 125 mililitres (ml) of chocolate milk, tomato juice, 180 ml of water, black tea, and juice or other was to be offered.
ii. Interview with the dietary aide who was serving beverages confirmed that the resident did not receive their tomato juice as outlined on the dinner beverage list.

B) On November 6, 2014, resident #001 was observed from 10:30 hours to 1400 hours. At approximately 13:30 hours, the resident requested to use the bathroom and was assisted by two staff members.
i. The plan of care for resident #001 indicated that the resident was incontinent of bladder related to impaired mobility and physiological changes. Interventions included but were not limited to incontinence program and staff were directed to remind and or assist to toilet before meals, after meals and before bed to prevent incontinent episodes.
ii. Review of Point of Care (POC) documentation from November 6, 2014, which indicated that the resident was toileted after breakfast at 9:55 hours.
iii. Interview with direct care staff confirmed that the resident was not reminded or assisted to the toilet before being assisted to the dining room for lunch as outlined in the plan of care. (528)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 12, 2014

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 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
Performance Improvement and Compliance 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 28th day of November, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cynthia DiTomasso

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