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**

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Apr 29, 2015 | 2015_250511_0005 | H-001828-15 | Resident Quality Inspection |

### 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

ROBIN MACKIE (511), CAROL POLCZ (156), IRENE PASEL (510), LAURA BROWN-HUESKEN (503)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): March 4, 5, 6, 9,10,11,12,13, 16,17 and 18, 2015**

**During this inspection the following complaints, critical incident and follow-ups were completed:**
**H-001844-15, H-001816-15, H-001817-15, H-000502-14, H-000495-14, H-000497-14, H-000499-14, H-000355-13, H-01140-14, H-000459-14, H-001597-14, H-001657-14, H-001521-14, H-000156-14.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Dietary Manager, Assistant Dietary Manger, Dietitian, Laundry/Housekeeping Manager, Associate Director of Care (ADOC)/Clinical Coordinator/Infection Control, ADOC/Staff Development Coordinator, Registered Nurses (RN's), Registered Practical Nurses (RPN's), housekeeping staff, Personal Support Workers (PSW's), dietary staff, residents, family members.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Housekeeping**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Dining Observation**
**Family Council**
**Food Quality**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Residents' Council**
**Safe and Secure Home**
**Skin and Wound Care**
**Sufficient Staffing**

**During the course of this inspection, Non-Compliances were issued.**

**10 WN(s)**
**4 VPC(s)**
**3 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 |
|---|---|---|---|
| LTCHA, 2007 S.O. 2007, c.8 s. 24. (1) | CO #001 | 2014_214146_0005 | 510 |
| LTCHA, 2007 S.O. 2007, c.8 s. 3. (1) | CO #003 | 2014_214146_0005 | 510 |
| LTCHA, 2007 S.O. 2007, c.8 s. 31. (2) | CO #005 | 2014_214146_0005 | 503 |
| LTCHA, 2007 S.O. 2007, c.8 s. 6. (1) | CO #001 | 2014_267528_0035 | 511 |
| O.Reg 79/10 s. 72. (3) | CO #004 | 2013_191107_0003 | 503 |
| O.Reg 79/10 s. 8. (1) | CO #001 | 2014_312503_0025 | 503 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:**
**1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).**

**s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:**
**3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that each resident admitted to the home was screened for tuberculosis within 14 days of admission unless the resident had already been screened at some time in the 90 days prior to admission and the documented results of this screening was available to the licensee.

Section 229. (10) (1) was issued as a VPC in a previous inspection in March 2014.

A review of the clinical records for residents #019 and #026 revealed that on admission to the home both residents were ordered chest x-rays to screen for tuberculosis; however, the x-ray results were not located. Interview with the DOC confirmed that the chest x-rays were not completed for the identified residents and that they had not been screened for tuberculosis. [s. 229. (10) 1.]

2. The licensee failed to ensure that residents were offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunizations schedules posted on the ministry website.

A review of the clinical records for residents #019, #026 and #402 revealed that the residents were not offered immunizations against tetanus and diphtheria. Interview with the DOC confirmed that the home had not offered the tetanus and diphtheria to all residents. [s. 229. (10) 3.]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training**

**Specifically failed to comply with the following:**

**s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that persons who received training under subsection (2) received retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Section 76. (4) was issued as a VPC in a previous inspection in September 2014.

Although policy #02-02-04 titled "Resident Abuse" did not direct that annual training on abuse be undertaken, the home did provide this training annually. The Director of Care (DOC) provided sign-in sheets for the 2014 annual training on abuse. There are 82 staff signatures that confirmed attendance at the 2014 annual abuse training. The DOC advised there were approximately 200 staff at the Home. The DOC confirmed that all staff did not receive the annual retraining on the Home's policy to promote zero tolerance of abuse and neglect of residents. [s. 76. (4)]

2. On an identified month in 2014, resident #403 reported to an RPN that a staff member had touched them inappropriately. A review of the identified employee's file found that the employee had not received annual training on the home's policy to promote zero tolerance of abuse and neglect of residents in 2013 or 2014. An interview with the ADOC Clinical Coordinator revealed that the training was not provided to the home's staff in 2013 and the identified staff had not attended the training offered in 2014. [s. 76. (4)]

***Additional Required Actions:***

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

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**WN #3: 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 failed to ensure that (b) a resident that exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment and (iii) was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented, and (iv) was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Section 50. (2) (b) was issued as a CO (Compliance Order) on a previous inspection in March 2014.
A review of the clinical record for resident #302 indicated the resident was at a high risk for alteration in skin integrity related to their high nutritional risk, incontinence and decreased mobility. Their medical condition required the resident to be totally dependent for all their care needs. A review of the home's Wound Assessment document, that the home referred to as their document for weekly wound assessments, indicated the resident had multiple wounds in a four month period in 2014. A review of the resident's clinical record did not indicate weekly skin and wound assessments were completed for these alterations in skin integrity.
The nursing progress notes indicated one of the wounds had reopened during this four month time frame and no weekly wound assessments were completed when the wound was noted to have reopened. Interview with the home's RD confirmed they assessed the resident prior to the wound reopening and had not received a referral, nor assessed the resident at the time when the wound had reopened. The RD confirmed the next assessment was at the next quarterly review date which was two months later.
Interview with the RPN on the floor and the DOC confirmed weekly skin and wound assessments were not completed for resident #302's wounds.

***Additional Required Actions:***

***CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).**

**Findings/Faits saillants :**

1. The licensee did not ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A review of the clinical documentation for resident #002, #012 and #301 indicated these three residents had incontinence of their bladder and required staff assistance with toileting. Each resident's plan of care identified the intervention to assist the resident to the toilet before and after each meal and at bedtime. The Point of Care (POC) documentation indicated the residents were toileted once per shift. Interview with the two PSW's, who provided care to these residents, stated they toileted the residents before and after each meal but only documented once per shift as per the home's toileting schedule. The PSW's confirmed charting only once per shift despite toileting these residents several times per shift. Interview with the DOC and the MDS coordinator confirmed the staff do not document each of the toileting interventions and responses to interventions. [s. 30. (2)]

2. The plan of care for resident #026 directed staff to apply a seat belt restraint while the resident was seated in their wheelchair. A review of POC documentation and observations of the resident revealed that the seat belt restraint was being applied during the day while the resident was seated in their wheelchair. A review of the treatment administration record (TAR) revealed that registered staff were not documenting that the resident's condition had been assessed for the months of January, February and March 2015. Interview with registered nursing staff revealed that the staff were assessing the resident on each shift but were not documenting this as completed in the TAR. Interview with the ADOC Clinical Coordinator confirmed that that the resident's condition had not been documented as assessed every 8 hours. [s. 30. (2)]

***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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices**

**Specifically failed to comply with the following:**

**s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:**
**2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that restraining of a resident was included in the resident's plan of care only if alternatives to restraining had been considered, and tried where appropriate, but would not be or had not been, effective to address the risk referred to in paragraph one.

The plan of care for resident #014 directed staff to apply a seat belt restraint while the resident was seated in their wheelchair. Interview with registered staff revealed that the restraint was applied at request of the resident's family. A review of the clinical record for resident #014 did not locate a reference to alternatives to restraining that were considered or tried. Interview with the ADOC/Clinical Coordinator confirmed that alternatives to the seat belt had not been considered or trialed for the resident. [s. 31. (2) 2.]

2. The plan of care for resident #026 directed staff to apply a seat belt restraint while the resident was seated in their wheelchair. A review of the clinical record for resident #026 did not locate a reference to alternatives to restraining were considered or tried. Interview with the ADOC Clinical Coordinator confirmed that alternatives to the seat belt had not been considered or trialed for the resident. [s. 31. (2) 2.]

***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 restraining of resident #014 and #026 are included in the resident's plan of care only if alternatives to restraining have been considered, and tried where appropriate, but would not be or have not been, effective to address the risk referred to in paragraph one, to be implemented voluntarily.***

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**WN #6: 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. (1) The continence care and bowel management program must, at a minimum, provide for the following:**
**5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).**

**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).**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,**
**(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the continence care and bowel management program must, at a minimum, provided for the following: 5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts were negotiated or renegotiated.

A review of the resident continence program, #05-04-12 had not identified an annual evaluation of residents' satisfaction with the range of continence care products was included in the home's continence program. An interview with the Resident Council President and Vice-President confirmed an annual evaluation was not provided to the residents to rate their satisfaction with the continence products. Interview with the Administrator confirmed the home`s continence care and bowel management program

did not include an annual evaluation that provided for consultation with residents to identify the residents' satisfaction with the range of continence care products. [s. 51. (1) 5.]

2. The licensee failed to ensure that each resident who was incontinent received an assessment that included 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 required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

1. A review of the clinical record for resident #002 identified they experienced a chronic decline in their intellectual functioning and were frequently incontinent of their bladder. The most recent plan of care indicated the resident used an incontinent product and required assistance from the staff for their toileting and continent needs. Further review of the clinical record did not identify a continence assessment was completed using a clinically appropriate assessment instrument that was specifically designed for assessment for incontinence. Interview with the MDS-RAI Coordinator confirmed the resident had not received an assessment, using a clinically appropriate assessment tool, that included identification of causal factors, patterns, type of incontinence and potential to restore function.

2. A review of the MDS assessments, section H, for resident #012 identified they experienced a change in their frequency of bladder incontinence between October 2014 and January 2015. The most recent plan of care indicated the resident used an incontinent product and required assistance from the staff for their toileting and the resident's bladder control pattern was to be evaluated. Further review of the clinical record did not identify a continence assessment was completed using a clinically appropriate assessment instrument that was specifically designed for assessment for incontinence. Interview with the MDS-RAI Coordinator confirmed the resident had not been reevaluated using a clinically appropriate assessment tool, that included identification of causal factors, patterns, type of incontinence and potential to restore function. [s. 51. (2) (a)]

3. The licensee failed to ensure that (b) each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

Resident #002 and #012 had been identified in the Resident Quality Inspection to be at a low risk for incontinence but were coded by registered staff, on the most recent quarterly MDS assessment, to be frequently or totally incontinent during the 14 day observation period. Both residents required assistance from the staff to be toileted. A review of the most recent plan of care for resident #002 and #012 indicated the residents were to to toileted before and after each meal and every night. Further review of the clinical record could not identity a continence assessment for either resident that identified the resident's patterns and types of incontinence. Interview with the MDS coordinator and the DOC confirmed the home had not assessed the patterns or type of incontinence for these two residents and the residents were toileted on a home schedule of before and after meals. The DOC confirmed resident #002 and #012 did not have an individualized plan, based on their assessed continence needs, to promote and manage bowel and bladder continence. [s. 51. (2) (b)]

***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 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, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production**

**Specifically failed to comply with the following:**

**s. 72. (2) The food production system must, at a minimum, provide for,**
**(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).**

**s. 72. (5) If any food or beverages are prepared in the long-term care home for persons who are not residents of the home, the licensee shall maintain, and keep for at least seven years, records that specify for each week,**
**(a) the number of meals prepared for persons who are not residents of the home; and O. Reg. 79/10, s. 72 (5).**
**(b) the revenue and internal recoveries made by the licensee relating to the sale or provision of any food and beverage prepared in the home, including revenue and internal recoveries made from cafeteria sales and catering. O. Reg. 79/10, s. 72 (5).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the food production system provided for preparation of all menu items according to the planned menu.

The preparation of the lunch meal was observed on March 12, 2015 and not all items were prepared according to the planned menu.

A) The ingredient list on the Irish Stew recipe did not include barbeque sauce. The cook was observed to use an unmeasured amount of barbeque sauce to the stew.
B) The ingredient list for the minced carrots and French style green beans did not include thickener. The ingredient list for the pureed carrots and French style green beans included a specified amount of thickener to be added in the preparation of the items. A dietary aide was observed to add an unmeasured amount of thickener to minced and pureed carrots and French style green beans.
An interview with the Dietary Manager confirmed that the items were not prepared as per the directions in the standardized recipes as part of the planned menu. [s. 72. (2) (d)]

2. The licensee failed to maintain records that specified for each week the number of meals prepared for persons who were not residents of the home and the revenue and internal recoveries made by the licensee relating to the sale or provision of any food and beverage prepared in the home.

A) The inspector observed a volunteer preparing a light lunch for the home's Family Council on March 12, 2015. Interviews with the Dietary Manager and the home's Administrator revealed that the cost of the meal was not from the raw food budget; however, records were not kept to support this.
B) Inspectors observed staff purchase leftover food from the lunch meal on March 11, 2015. Interviews with the Dietary Manager and the home's Administrator revealed that staff pay the home for the purchase of food leftover at the end of meal services and that this money was deposited into the dietary department's accounts; however, weekly records were not kept for the sale of these items. [s. 72. (5)]

***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 food production system provides for preparation of all menu items according to the planned menu, to be implemented voluntarily.***

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**WN #8: 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. (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 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, (a) a goal in the plan was met; (b) the resident's care needs changed or care set out in the plan was no longer necessary.

A review of resident #005's clinical record indicated they had multiple wounds from August 2014 to January 2015. These wounds required medical treatment and nursing interventions and were documented as fully healed by February 2015. The most recent plan of care was reviewed in March 2015 and indicated the resident still had wounds that required nursing intervention. This same plan of care also indicated the resident had pain related to their wounds and required medication for pain as prescribed by the doctor. Interview with a PSW, who provided care to this resident, stated the resident`s skin was intact. Interview with the MDS Coordinator confirmed the plan of care was not reviewed and revised when care set out in the plan was no longer necessary. [s. 6. (10)]

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**WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance**

**Specifically failed to comply with the following:**

**s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that suspected abuse of a resident, by anyone or neglect of a resident, was immediately reported to the Director.

The home's " Resident Abuse" policy, # 02-02-04, directed nursing staff to report all incidents of suspected mistreatment of residents to the home's DOC immediately. If the DOC is not on duty, the policy directed staff to report the incident to the Charge Nurse, who is then directed to report to contact the Ministry of Health to report the incident.
On a specific month and day in 2014 resident #403 reported to an RPN that a staff member had touched them inappropriately. The incident was reported to the DOC 24 hours later and the DOC reported the incident to the Director. Interview with the home's Administrator and DOC confirmed that the RPN had not complied with the home's "Resident Abuse" policy by reporting the incident to the Charge Nurse immediately for report to the Ministry of Health as the DOC was not on duty at the time of the incident. [s. 20. (1)]

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**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints**

**Specifically failed to comply with the following:**

**s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,**
**(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).**
**(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).**
**(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).**
**(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).**
**(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).**
**(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that a documented record was kept in the home that included (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

Resident #302 had  a confirmed injury during a specific month in 2014. The POA had made a written complaint to the home that indicated they were not satisfied with the response that they had received regarding their mother's injury and requested the home provide an explanation of what happened with supporting documentation.  There was no documented record, by the home, for the initial complaint as mentioned in the POA's complaint letter. There was a response letter from the home acknowledging a face to face discussion. A review of the Home's complaint process, document 09-04-06, "Dealing with Complaint" directed the licensee to maintain a file with a copy of all written complaints (Heritage Green Nursing Home Complaint Form) including a description of follow-up actions taken and the date the feedback was provided to the complainant. A review of the documented records for this complaint was incomplete and did not include all the information as prescribed by r.101.(2). Interview with the DOC confirmed the licensee did not ensure that a documented record was kept in the home that included:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant. [s. 101. (2)]

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 21st day of May, 2015**

**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) :** | ROBIN MACKIE (511), CAROL POLCZ (156), IRENE PASEL (510), LAURA BROWN-HUESKEN (503) |
| **Inspection No. / No de l'inspection :** | 2015_250511_0005 |
| **Log No. / Registre no:** | H-001828-15 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Apr 29, 2015 |
| **Licensee / Titulaire de permis :** | HERITAGE GREEN NURSING HOME<br>353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3 |
| **LTC Home / Foyer de SLD :** | HERITAGE GREEN NURSING HOME<br>353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Rosemary Okimi |

To HERITAGE GREEN NURSING HOME, 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. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:

1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

O. Reg. 79/10, s. 229 (10).

**Order / Ordre :**

The licensee shall ensure that all current residents and each resident admitted to the home is screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

**Grounds / Motifs :**

1. The licensee failed to ensure that each resident admitted to the home was screened for tuberculosis within 14 days of admission unless the resident had already been screened at some time in the 90 days prior to admission and the documented results of this screening was available to the licensee.

The Licensee had previous non-compliance for immunization and screening and was issued a Voluntary Plan of Correction (VPC) in March 2014 and a Written Notice (WN) in February 2012.

A review of the clinical records for residents #019 and #026 revealed that on admission to the home both residents were ordered chest x-rays to screen for tuberculosis; however, the x-ray results were not located. Interview with the DOC confirmed that the chest x-rays were not completed for the identified residents and that they had not been screened for tuberculosis.
(503)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** May 15, 2015

**Order # / Ordre no :** 002

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

**Order / Ordre :**

The licensee shall ensure that all staff receive annual training on the home's policy to promote zero tolerance of abuse and neglect of residents.

**Grounds / Motifs :**

1. The licensee failed to ensure that all staff received annual training on the home's policy to promote zero tolerance of abuse and neglect of residents.

Section 76. (4) was issued as a VPC in a previous inspection in September 2014.

A) During a specific month in 2014 resident #403 reported to an RPN that a staff member touched them inappropriately. A review of the identified employee's file found that the employee had not received annual training on the home's policy to promote zero tolerance of abuse and neglect of residents in 2013 or 2014. An interview with the ADOC Clinical Coordinator revealed that the training was not provided to the home's staff in 2013 and the identified staff had not attended the training offered in 2014. (503)

B) Although policy #02-02-04 titled Resident Abuse does not direct that annual training on abuse be undertaken, the home does offer this training annually. The Director of Care (DOC) provided sign in sheets for the 2014 annual training on abuse. There were 82 staff signatures that confirmed attendance at the 2014 annual abuse training. The DOC advised there were approximately 200 staff at the Home. The DOC confirmed that all staff had not received annual retraining on the Home's policy to promote zero tolerance of abuse and neglect of residents. (510) (503)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Sep 18, 2015

**Order # / Ordre no :** 003

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

**Linked to Existing Order / Lien vers ordre existant:** 2014_214146_0005, CO #008;

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

**Order / Ordre :**

The licensee shall ensure that resident #302 receives a skin assessment by a member of the registered nursing staff, (b) when 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, (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).

**Grounds / Motifs :**

1. The licensee failed to ensure that (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment and (iii) was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented, and (iv) was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Section 50. (2) (b) was issued as a CO (Compliance Order) on a previous inspection in March 2014.

A review of the clinical record for resident #302 indicated the resident was at a high risk for alteration in skin integrity related to their high nutritional risk, incontinence and decreased mobility. Their medical condition required the resident to be totally dependent for all their care needs. A review of the home's Wound Assessment document, that the home referred to as their document for weekly wound assessments, indicated the resident had multiple wounds in a four month period in 2014. A review of the resident's clinical record did not indicate weekly skin and wound assessments were completed for these alterations in skin integrity.

The nursing progress notes indicated one of the wounds had reopened during this four month time frame and no weekly wound assessments were completed when the wound was noted to have reopened. Interview with the home's RD confirmed they assessed the resident prior to the wound reopening and had not received a referral, nor assessed the resident at the time when the wound had reopened. The RD confirmed the next assessment was at the next quarterly review date which was two months later.

Interview with the RPN working on the floor and the DOC confirmed weekly skin and wound assessments were not completed for resident #302's wounds. (511)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** May 15, 2015

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

## 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 29th day of April, 2015**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Robin Mackie

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