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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Feb 21, 2017	2017_570528_0005	001184-16, 021399-16, 021403-16, 021405-16, 021416-16	Follow up

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 Follow up inspection.

This inspection was conducted on the following date(s): February 9 and 10, 2017

This inspection included follow up inspection log #'s: 021399-16 and 021403-16 related to plan of care, 021403-16 related to general requirements of a program, 021405-16 related to abuse and neglect
02416-16 related to mandatory education.

This inspection was completed concurrently with CIS inspection #2017_570528_0004

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Staff Educator, the Programs Manager, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), activity staff, and residents and families.

During the course of the inspection, the inspector also observed the provision of care and services, reviewed policies and procedures, clinical health records, and education records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 VPC(s)**
- **1 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. 19. (1)	CO #003	2016_323130_0007	528
O.Reg 79/10 s. 30. (1)	CO #002	2015_189120_0092	528
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #002	2016_323130_0007	528
LTCHA, 2007 S.O. 2007, c.8 s. 76. (4)	CO #005	2016_323130_0007	528

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. (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).

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 care set out in the plan of care was provided to the resident as specified in the plan.

A. On an identified day in February 2017, resident #029 was observed seated in their wheelchair in the hallway, a device was attached to the wheelchair but not applied to the resident. Review of the plan of care identified that the resident was a high risk for falls and required fall prevention interventions. Interview with PSW #101 confirmed that the resident required the device to alert staff as to whether the resident was trying to get out of the chair; however, the device was not attached to the resident and therefore not applied as required in their plan of care. (528)

B. On an identified day in February 2017, resident #021 was observed seated in the lounge and did not appear to be wearing safety devices. Interview with PSW #103 confirmed the resident had not had the devices applied on that day. PSW #101 confirmed that the devices were not placed on the resident, as they were being laundered. Review of the resident's plan of care identified that the resident was at a high risk for falls and required the safety devices at all times. Interview with and PSW #101 and RN #100 confirmed that the home had an extra supply of safety devices, for when the resident's go missing or go down to laundry. The safety devices were not placed on the resident as required in the plan of care. (528)

C. On an identified day in February 2017, resident #032 was observed seated in their wheelchair. A device was placed on the wheelchair but the device was not attached to the resident. Review of the plan of care identified that the resident was at risk for falls

and directed staff to ensure the device was in good working condition and applied correctly to the resident's body. Interview with RPN #107 confirmed that the resident required the device and it was not applied to the resident's body; therefore, not applied as required in the plan of care. (528) [s. 6. (7)]

2. 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 the resident's care needs changed or care set out in the plan was no longer necessary.

A. On an identified day in February 2017, resident #010 was observed seated in their wheelchair. Review of the written plan of care, including the document the home refers to as the care plan and point of care documentation did not include any mention that the resident required the use of a tilt wheelchair. Interview with RN #100 confirmed that in October 2016, the physician ordered that the wheelchair could be tilted as a restraint for the resident's safety. RN #100 also confirmed that the written plan of care was not updated to include that the resident was using the tilt wheelchair as a restraint. (528)

B. In December 2016, resident #030 was assessed to be at a high risk for falls. Review of the written plan of care stated that the resident was at a moderate risk for falls. Interview with RN #100 confirmed that the resident was assessed to be a high risk for falls but the written care plan was not updated with the increased risk. (528) [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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).

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:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the restraint plan of care included alternatives to restraining that were considered, and tried, but had not been effective in addressing the risk.

During the course of the inspection, resident #030 was observed seated in a wheelchair that had a tilt feature. Interview with PSW #108 confirmed that the resident was tilted at times. Interview with RN #105 confirmed that the resident used the tilt wheelchair as a physical restraint since October, 2016. Review of the plan of care did not include an assessment of the restraint required by the home titled "Restraint Assessment", in Point Click Care, including alternatives to restraining. Interview with RN #105 confirmed an assessment for the tilt restraint was not completed, as required in the home's policy . (528)

B. On an identified day in February 2017, resident #010 was observed seated in a wheelchair. Interview with RN #100 confirmed that the resident required the tilt wheelchair as a restraint. Review of the plan of care included a physican order for the restraint from October 2016; however, did not include an assessment of the restraint required by the home titled "Restraint Assessment", in Point Click Care, including alternatives to restraining. Interview with RN #105 confirmed an assessment for the tilt restraint was not completed, as required in the home's policy . (528) [s. 31. (2) 2.]

2. The licensee failed to ensure that the restraint plan of care included the consent by the resident or if the resident is incapable, by the SDM.

In October 2016, a physican's order identified that resident #010 was to be placed in tilt back position as a restraint for safety as needed. Review of the plan of care did not include consent from the resident's substitute decision maker. Interview with RN #100 confirmed that the resident used the tilt back position and no consent was obtained from the resident's Public Guardian and Trustee. (528) [s. 31. (2) 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 restraint plan of care includes the following:
i. alternatives to restraining that are considered, and tried, but had not been effective in addressing the risk
ii. the consent by the resident or if the resident is incapable, by the SDM, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the documentation included all assessment, reassessment and monitoring, including the resident's response.

A. On an identified day in February 2017, resident #010 was observed seated in their wheelchair. Review of the plan of care identified that in October 2016, the tilt feature of the wheelchair was ordered by the physician to be used as a restraint for the resident's

safety; however, the plan of care did not include restraint documentation including an initial Restraint Assessment, as well as hourly monitoring, and reassessment of the device every eight hours, as required. Interview with RN #100 confirmed that since the use of the tilt feature was initiated in October 2016, restraint documentation was not completed by both PSW and registered staff as required. RN #100 also confirmed that the resident continued to require the device and was monitored by staff but it was not documented.

B. During the course of the inspection, resident #030 was observed seated in a wheelchair that had a tilt feature. Interview with PSW #108 confirmed that the resident is tilted at times. Interview with RN #105 confirmed that the resident used the tilt wheelchair as a physical restraint since October 2016. Review of the plan of care did not include documentation of initial restraint assessment, reassessment and monitoring of the restraint by registered or PSW staff, confirmed by RN #105. Interview with RN #105 confirmed that the resident required the tilt wheelchair and was monitored as required, but information was not documented. (528) [s. 110. (7) 6.]

2. The licensee failed to ensure that the documentation included every release of the device and repositioning.

On an identified day in February 2017, resident #010 was observed seated in their wheelchair. Review of the plan of care identified that in October 2016, the tilt feature of the wheelchair was ordered by the physician to be used as a restraint for the resident's safety; however, the plan of care did not include restraint documentation including but not limited to releasing the restraint and repositioning the resident as required. Interview with RN #100 confirmed that since the use of the tilt feature was initiated in October 2016, restraint documentation was not completed by both PSW and registered staff as required. Observations during the course of the inspection and interviews with RN #100 confirmed that the resident was repositioned and device released every two hours, as required. (528)

B. During the course of the inspection, resident #030 was observed seated in a wheelchair that had a tilt feature. Interview with PSW #108 confirmed that the resident is tilted at times. Interview with RN #105 confirmed that the resident used the tilt wheelchair as a physical restraint since October 2016. Review of the plan of care did not include documented releasing of the device and reposition of the resident by PSW or regsitered staff. Interview with RN #105 confirmed, documentation was not completed as required with application of restraints. Observations during the course of the inspection

and interviews with RN #105 confirmed that the resident was repositioned and device released every two hours, as required. (528) [s. 110. (7) 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 documentation includes the following:
i. all assessment, reassessment and monitoring, including the resident's response
ii. every release of the device and repositioning, to be implemented voluntarily.

Issued on this 21st day of February, 2017

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CYNTHIA DITOMASSO (528)
Inspection No. / No de l'inspection :	2017_570528_0005
Log No. / Registre no:	001184-16, 021399-16, 021403-16, 021405-16, 021416-16
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Feb 21, 2017
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 :	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) (b)

Linked to Existing Order / Lien vers ordre existant: 2016_323130_0007, CO #001;

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 prepare, submit and implement a plan to ensure that the care set out in the plan of care for all residents, including but not limited to, residents #021 #029 and #032, is provided to the resident as specified in the plan, related to fall prevention interventions and strategies to mitigate risks to residents.

The plan shall include but not be limited to:
1. Education to all front line staff regarding the plan of care and expectations and directions of staff to ensure that the plan of care is provided to the resident.
2. Conduct auditing activities, at regular intervals, to ensure that fall prevention intervention and strategies to mitigate the risk to residents are provided to residents as specified in their plan of care.

The plan is to be submitted to cynthia.ditomasso@ontario.ca by March 23, 2017.

Grounds / Motifs :

1. This non-compliance had a severity of "potential for actual harm/risk", with a scope "pattern" and an ongoing history of noncompliance with CO issued on April 29 2015, related to food production and on June 28, 2016, related to fall prevention interventions safe lift and transfer techniques, and established toileting routines.

A. On an identified day in February 2017, resident #029 was observed seated in their wheelchair in the hallway, a device was attached to the wheelchair but not applied to the resident. Review of the plan of care identified that the resident was a high risk for falls and required fall prevention interventions. Interview with PSW #101 confirmed that the resident required the device to alert staff as to whether the resident was trying to get out of the chair; however, the device was not attached to the resident and therefore not applied as required in their plan of care. (528)

B. On an identified day in February 2017, resident #021 was observed seated in the lounge and did not appear to be wearing safety devices. Interview with PSW #103 confirmed the resident had not had the devices applied on that day. PSW #101 confirmed that the devices were not placed on the resident, as they were being laundered. Review of the resident's plan of care identified that the resident was at a high risk for falls and required the safety devices at all times. Interview with and PSW #101 and RN #100 confirmed that the home had an extra supply of safety devices, for when the resident's go missing or go down to laundry. The safety devices were not placed on the resident as required in the plan of care. (528)

C. On an identified day in February 2017, resident #032 was observed seated in their wheelchair. A device was placed on the wheelchair but the device was not attached to the resident. Review of the plan of care identified that the resident was at risk for falls and directed staff to ensure the device was in good working condition and applied correctly to the resident's body. Interview with RPN #107 confirmed that the resident required the device and it was not applied to the resident's body; therefore, not applied as required in the plan of care. (528) [s. 6. (7)] (528)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 24, 2017

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 21st day of February, 2017

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