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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 2, 2019	2019_569508_0013	005214-19	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

ROSEANNE WESTERN (508), KELLY CHUCKRY (611)

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): March 7, 8, 11, 12, 13, 14 and 15, 2019.

During the course of the inspection, the inspector(s) toured the facility, observed the provision of care, reviewed resident clinical records, the 2018 complaint log, medication incident reports, relevant policies and procedures and staff training records.

PLEASE NOTE: This complaint inspection was conducted concurrently during a Critical Incident (CI) inspection #2019_569508_0014.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Clinical Care Coordinator, the Resident Assessment Instrument (RAI) Coordinator, Behavioural Support of Ontario (BSO) staff, registered staff, Personal Support Workers (PSW)s, residents and family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents who required continence care products had sufficient changes to remain clean, dry and comfortable.

During this inspection, it was identified that resident #001 demonstrated responsive behaviours due to their cognitive impairment. The resident also required total assistance from staff for a specific intervention at identified times.

On an identified date in 2019, it was identified that PSW staff #104 attempted to provide a specific intervention to resident #001; however, PSW staff #104 indicated that the resident had responsive behaviours and staff could not provide the care to the resident.

During interviews with staff #104 and staff #105, it was confirmed that the resident was not provided an intervention. PSW staff #104 indicated that the resident was sleeping at and was left to sleep in longer. A review of the documentation indicated that care had been provided at a specific time on that shift; however, interview with the PSW staff who documented this, confirmed that this had not taken place. Clinical records reviewed indicated that the resident had not had this specific intervention provided to them since the previous evening.

It was confirmed during interviews and review of the resident's clinical records that the resident who required continence care products did not have sufficient changes to remain clean, dry and comfortable. [s. 51. (2) (g)]

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 residents who require continence care products have sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible.

During this inspection, it was identified that resident #001 demonstrated responsive behaviours due to their cognitive impairment. Specific interventions had been developed to respond to these behaviours.

During an observation by the Long Term Care Home (LTCH) Inspectors #508 and #611 on an identified date, it was observed that care had not been provided to the resident. The staff indicated during interview that the resident was exhibiting responsive behaviours. It was identified that not all interventions that had been developed were being implemented to manage the resident's responsive behaviours.

It was confirmed during record review, interviews and observations that strategies had not been developed and implemented to respond to the resident who demonstrated responsive behaviours. [s. 53. (4) (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 for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.

WN #3: 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 the resident's needs changed or care set out in the plan was no longer necessary.

The written plan of care for resident #001, indicated that this resident was at risk for falls. The plan of care outlined interventions that were to be in place, to prevent injury as a result of falls. Specific interventions were implemented.

During the course of this inspection, resident #001 was observed multiple times without these specific interventions in place. An assessment revealed that the resident had a change in their condition and specific interventions were no longer applicable.

In an interview conducted with staff #102, it was confirmed that resident #001 had a change in their condition. It was further confirmed that the interventions identified for resident #001 were no longer appropriate interventions for this resident. Staff #102

confirmed the plan of care for resident #001 was not reviewed and revised when their care needs changed.

In an interview with the Directer of Care, it was confirmed that the plan of care for falls prevention for resident #001 was not reviewed and revised when their care needs changed. [s. 6. (10) (b)]

2. The licensee failed to ensure that the plan of care was 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.

During this inspection, it was identified that resident #001's current bathing plan of care directed staff to provide the resident with a specific type of bath, on specific days and at specific times. During interview with staff #103, they indicated they were unsure of the resident's current bathing needs. Review of the documentation over an identified period of time, verified that the resident had not been receiving bathing care as per their plan of care.

It was revealed that the interventions for bathing had been changed; however, the plan that staff refer to for direction in providing care to the resident had not been revised.

It was confirmed through record review and during interviews, that the resident's current plan of care had not been reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a care conference of the interdisciplinary team was held to discuss the plan of care and any other matters of importance to the resident and his or her Substitute Decision Maker (SDM) within six weeks of the admission of the resident.

During this inspection, it was identified that resident #001 was admitted to the home on an identified date in 2018. The resident had appointed a SDM who was making care decisions for the resident due to their cognitive impairment.

A review of the resident's clinical record indicated that the SDM had raised a number of concerns with registered staff #106 regarding the resident's care after their admission. The SDM indicated at this time that they had not had their 6 week post admission care conference. Clinical records confirmed that a post admission care conference was not held almost three months after the resident's admission.

It was confirmed during record review and during an interview with the Administrator, that an interdisciplinary care conference had not been held for resident #001 and their SDM within six weeks of their admission. [s. 27. (1)]

Issued on this 10th day of April, 2019

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

Original report signed by the inspector.