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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 9, 2019	2019_575214_0025	018599-18, 032379-18, 004874-19	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

CATHY FEDIASH (214), ROSEANNE WESTERN (508)

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): July 30, 31, August 1, 2, 6, 7, 8, 12, 13, 14, 15, 16, 2019.

This inspection was conducted simultaneously with critical incident inspection #2019_575214_0026 / 014151-18, 017307-18, 022646-18, 013347-19, 014574-19.

The following intakes were completed during this complaint inspection:
018599-18- related to personal support services; continence care and bowel management; medication management system; dining and snack service; weight changes; residents' Bill of Rights.

032379-18- related to plan of care; skin and wound; residents' Bill of Rights.

004874-19- related to nursing and personal support services; personal support services; skin and wound; maintenance services; availability of supplies.

PLEASE NOTE: A Written Notification (WN) related to O. Reg. 79/10, r. 8 (1)(b) and r. 30 (2), identified in a concurrent inspection #2019_575214_0026 / 014151-18, 017307-18, 022646-18, 013347-19, 014574-19 (log #013347-19, CIS #2776-000033-19) was issued in this report.

During the course of the inspection, the inspector(s) spoke with Administrator; Director of Care (DOC); Assistant Director of Care (ADOC); Assistant Administrator; Nursing Ward Clerk; Registered Dietician (RD); Maintenance Manager; Pharmacy Technician; Registered staff; Personal Support Workers (PSW); residents and families.

During the inspection, the inspector(s) reviewed complaints; meeting minutes; resident clinical records; policies and procedures; maintenance requisitions; staff training records; program evaluations and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Personal Support Services
Skin and Wound Care
Sufficient Staffing

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

5 WN(s)
1 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 :

A review of complaint intake #004874-19, indicated that the care needs of resident’s were not being met as there was not enough staff.

On an identified date and time, the Ministry of Long Term Care (MOLTC) Inspector, observed care provided to the resident.

The resident verbalized to the MOLTC Inspector that they had been awake since an identified, approximate hour and had not received any assistance with an identified activity of daily living (ADL) for approximately seven and a half hours. The resident verbalized how they felt.

During the observation of the resident’s identified ADL, specified observations had been made.

An interview with PSW staff #110 and #112, confirmed that they started their shift at an identified time. The staff confirmed an identified outcome for the resident and that staff were to ask the resident at a specified time of day, if they required a specified task to be done. The MOLTC Inspector asked the staff if they had asked the resident if they required the specified task to be done. The staff indicated that an identified number of residents on the unit required a specified level of assistance with their ADL's and that there were a specified number of PSW’s on the unit. The staff indicated that this was the first time since the start of their shift that they were able to ask and assist the resident with the specified ADL. [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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act and Regulation required the licensee of a long-term care home to have, institute or otherwise put any procedure in place, the procedure was complied with.

(A) in accordance with the Long Term Care Homes Act (LTCHA), 2007, s. 8(1), and in reference to Ontario Regulation (O.Reg.) s. 114, the licensee was required to have a medication management system in place that ensured that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

Specifically, staff did not comply with the licensee's policy titled, "Documenting Transcription of Orders on Electronic MARs" [4.06(a)], which was part of the licensee's medication management program.

On an identified date and time resident #004's clinical chart was observed to be sitting on the counter on an identified unit. Two plastic flags were noted to be pulled upwards; one for "nurse to check" and another for "doctors orders". A review of the physician's orders indicated that on an identified date, the resident's physician wrote an order to decrease a specified drug. The time the order was written was blank. A review of the resident's progress notes had not contained any documentation to indicate the time the order was written. A review of the physician's order indicated that the area titled, Nurse #1 and Nurse #2, where nurses document that the order had been checked; entered onto the electronic Medication Administration Record (eMAR); resident care plan, family informed, and completed with the nurse's signature, date and time, was blank.

During an interview with registered staff #114 and #115, they confirmed that they had worked on the day the order was written, and both had not seen the resident's physician. Both registered staff indicated that physician's document in the resident's progress notes when they see a resident.

An interview was conducted with registered staff #116, who confirmed they had worked on the date the order was written. The staff member indicated that they did see the resident's physician on another unit, on an identified shift. The staff member indicated that they had seen physician's orders at a specified nursing station. The staff member indicated that they looked at specified types of orders only and did not process any of the orders. The staff member indicated that they were unable to recall if resident #004's chart and new physician's order had been on the identified unit as the resident resided on a different unit.

A review of the eMAR indicated that the pharmacy technician entered the order onto the eMAR the day after the physician wrote the order. The order was entered to begin on the day after it had been entered into the eMAR. An interview with the pharmacy technician indicated that they entered the order on this date as the day the physician wrote the order was a holiday and the pharmacy was closed.

A review of the eMAR indicated that resident #004 had received the original dose of the identified drug the day following the order to decrease the drug, by registered staff #114. During an interview with registered staff #114, they indicated that physician orders were to be first checked by the registered staff member who was working at the time the order is written. When there was a change in directions for a drug, the registered staff member who first checked the physician's order, was to place a "change in directions" sticker on the medication pouch, identifying the drug, so that other registered staff were aware there was a change and can check the orders and the eMAR.

A review of the above policy was conducted with the DOC and ADOC #104. Both confirmed that the procedure for processing physician's orders was as follows:

The registered staff member who was working on the shift in which the physician's order was written, was expected to inform and obtain consent from the resident or family regarding the physician's order and initial in this box on the order form. The nurse was then to check that the physician's order had been processed on the eMAR either by pharmacy staff and if not, was then to be entered in the eMAR by the home's registered staff and then initialed in the appropriate box on the order form. Any changes to the

resident care plan or laboratory or dietary requisitions were to be completed and then initialed as complete in the appropriate box on the order form. The nurse then was to sign and date and list the time under "Nurse 1", on the Physician Order Form. The DOC confirmed that if the physician order was received close to shift change, the oncoming registered nurse, was to process the order as "Nurse 1". Preferably, on the same shift, a second registered staff was to check the orders and ensure that all steps involved for "Nurse 1", had been completed and then completes the information under "Nurse 2" by signing their full name, designation, the date and time. If a second nurse on the same shift was unable to complete the requirements for "Nurse 2", this was to be completed on the next shift. The DOC and ADOC confirmed that any change in a drug dose, was to have a "change in direction" sticker placed onto the packaging in which the drug was contained within.

The DOC and ADOC #104 confirmed the physician’s order for resident #004 had not been processed approximately 22 hours later and that the licensee’s procedure with respect to the processing of physician’s orders, had not been complied with.

B) PLEASE NOTE: The following non-compliance was identified during concurrent Critical Incident System (CIS) inspection #2019_575214_0026 / 014151-18, 017307-18, 022646-18, 013347-19, 014574-19, and was issued in this report.

In accordance with O. Reg. 79/10, s. 48(1).1, the licensee was required to have a specified, interdisciplinary program and in accordance with O. Reg. 79/10, s. 49(1), the licensee was required to ensure that the specified program must, at a minimum, provide for strategies to reduce or mitigate specified incidents, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

Specifically, the licensee did not comply with their "Neruological Signs: Head Injury Routine", policy number 08-01-27.

The home’s policy titled "Neruological Signs: Head Injury Routine", policy number 08-01-27, stated that the head injury routine (HIR) was to be implemented for all suspected or confirmed head injuries, unwitnessed falls and upon physician's orders.

A review of a CIS, whereby it was reported by the home that resident #008 sustained an identified, critical incident on an identified date, with injury.

Clinical records were reviewed and identified that resident #008 had a number of identified incidents in a specified year, and after an unwitnessed incident on an identified date, the HIR was not initiated.

Registered staff #122 was interviewed and stated that resident #008 had an unwitnessed incident on the identified date, and the HIR was not initiated but should have been as per the home’s policy.

The ADOC confirmed that the HIR should have been initiated for resident #008 after this unwitnessed incident.

The licensee failed to ensure that the home’s policy titled “Neruological Signs: Head Injury Routine", was complied with. [s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

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 has failed to ensure that the continence care and bowel management program was evaluated and updated at least annually.

A review of the continence care and bowel management program evaluation provided by ADOC #105, indicated that this program evaluation was dated approximately 18 months prior. During an interview with ADOC #105, it was confirmed that the last program evaluation was approximately 18 months prior. ADOC #105 indicated that the home did have a meeting booked to evaluate this program later in the month; however, the program had not been evaluated annually. [s. 30. (1) 3.]

2. The licensee failed 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 were documented.

The licensee has failed to ensure that actions taken with respect to resident #001's, specified ADL needs, were documented.

A) A review of complaint intake #004874-19, indicated that the care needs of resident's were not being met as there was not enough staff.

During an interview with resident #001, on an identified date, they verbalized to the MOLTC Inspector that they had been awake since an identified, approximate hour and had not received any assistance with an identified activity of daily living (ADL) for approximately seven and a half hours.

During a review of the Point of Care (POC) task for this specified ADL, specified documentation had been entered on an identified date and time. No further documentation was entered until approximately 12 and half hours later.

During an interview with PSW staff #113, they indicated that together with their co-worker, they provided the specified ADL care on a specified date and time for an identified reason. Staff #113 indicated that they initiated the specified ADL a second time, approximately three and a half to four hours later. Staff #113 indicated that staff do not usually document care provided the second time, for this specified ADL.

During an interview with ADOC #104 and #105, they confirmed that all actions, including this specified ADL, were to be documented in the POC documentation system.

B) PLEASE NOTE: The following non-compliance was identified during concurrent CIS inspection #2019_575214_0026 / 014151-18, 017307-18, 022646-18, 013347-19, 014574-19, and was issued in this report.

A review of the home's CIS report identified that resident #008 sustained an injury on an identified date.

Resident #008's clinical records were reviewed and identified that the resident had a specified number of identified incidents over a specified period of two months in an

identified year. The progress notes dated on a specified date, indicated that the resident was found in a specified location and their identified safety device had not been in place. During an interview with PSW #133 that provided direct care to the resident that day and stated that when they found the resident one part of their safety device was in a specified location and a second part of their safety device was in another specified location. PSW #133 stated that the resident had a history of demonstrating identified responsive behaviours in relation to their safety device. A progress note dated on an identified date, stated that the resident was noted to be demonstrating the identified responsive behaviour, in relation to their safety device. The pattern of this behaviour was not consistently being documented. Registered staff #122 was interviewed and stated that the resident had these identified responsive behaviours, in relation to their safety device. The written plan of care was reviewed and the resident’s identified responsive behaviour, in relation to their safety device, had not been documented in the written plan of care.

In an interview with the ADOC, they confirmed that the resident did have identified behaviours in relation to their safety device and this should have been documented in the resident’s care plan so that staff were aware of this behaviour.

The licensee failed to ensure that actions taken with respect to resident #008 under the identified program including interventions and the resident's responses to interventions were documented. [s. 30. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record related to the evaluation of the staffing plan, included the date of the evaluation and the names of the persons who participated in the staffing plan evaluation.

The MOLTC Inspector met with the DOC to review the staffing plan evaluation. A review of the staffing plan indicated that the date of the evaluation and the names of the persons who participated in the evaluation had not been included. The DOC indicated that the staff had met previously in an identified month and year to evaluate the staffing plan and that minutes of the meeting had been taken; however, were unable to be located at the time of this inspection. [s. 31. (4)]

WN #5: 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,
(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).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 was repositioned every two hours.

A review of complaint intake #004874-19, indicated that residents who were dependent for care and at risk for skin alterations, had not received a specified ADL as there was not enough staff.

A review of resident #001’s current, electronic care plan and a task in POC, indicated that the resident was to have a specified ADL provided at a specified frequency and with identified care.

On an identified date and time, the MOLTC Inspector, observed care provided to the resident.

During this time, the resident verbalized they had awoken at an identified time and had not had the specified ADL provided for approximately three and a half hours.

An interview with PSW staff #110 and #112, confirmed that they started their shift at a specified time. The staff confirmed that the resident was dependent upon staff for the specified ADL, at a specified frequency. The staff indicated they had not had a chance to provide the specified ADL until approximately three and half hours later, which was approximately one and a half hours later than required . The staff indicated that an identified number of resident on the unit required an identified level of assistance and that there were only a specified number of PSW’s on the unit. The staff indicated that this was the first time since the start of their shift that they were able to assist the resident with the specified ADL. [s. 50. (2) (d)]

Issued on this 23rd day of September, 2019

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

Original report signed by the inspector.