Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 27, 2019	2019_577611_0039	019960-19	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

KELLY CHUCKRY (611), YULIYA FEDOTOVA (632)

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): October 23, 24, 28, 29, 30, and 31, 2019.

PLEASE NOTE: This inspection is a complaint inspection Log #019960-19 pertaining to continence care, hospitalization and change of Condition, Personal Support Services, and Nutrition and Hydration. Complaint Log #019960-19 was received by the Hamilton Service Area Office. This complaint identified concerns pertaining to hydration management. This complaint was initially submitted as an anonymous complaint, and three residents were inspected upon as part of this complaint.

In addition, separate from the complaint, additional concerns were identified with respect to Nutrition and Hydration and were inspected on concurrently with this complaint inspection.

During the course of this inspection, the inspector(s) observed the provision of resident care, reviewed pertinent clinical health records, complaint logs, relevant policies and procedures, and pertinent job descriptions.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Assistant Administrator, Director of Care (DOC), Staff Development Coordinator, Clinical Care Coordinator, Food Service Manager (FSM), Registered Dietitian (RD), Registered staff, Personal Support Workers (PSWs), and the complainant.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Hospitalization and Change in Condition
Nutrition and Hydration
Personal Support Services

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

3 WN(s)
0 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 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 care needs change, or care set out in the plan was no longer necessary.

Resident #003 required external assessment and intervention on an identified date. Upon return to the home, the written plan of care for resident #003 identified that this resident required the same level of assistance with feeding as they did before the external assessment. During the inspection, resident #003 was observed during the lunch meal, and required a different level of assistance with their meal.

In an interview conducted with staff #105, it was identified that since the external assessment, resident #003 required a higher level of assistance with their meals. This was further confirmed by staff #116 on the same day.

In an interview conducted with the Staff Development Coordinator, it was confirmed that the plan of care for resident #003 was not reviewed and revised when their care needs changed.

WN #2: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the organized program of nutrition care and dietary services for the home was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices. [s. 30. (1) (3)]

A. During the inspection, RD #103 shared that they had to complete all dietary referrals in the home and had concerns with how timely they could respond to residents at nutrition risk due to the large number of referrals. The job description titled "Dietary Manager, 02-02-01B" dated February 2, 2001, directed the dietary manager to conduct dietary assessments in collaboration with the Dietitian.

In an interview with the Dietary/Food Service Manager they shared that completing dietary assessments was not part of their duties and responsibilities, and they were all completed by the RD. The Assistant Administrator and the Clinical Coordinator

confirmed this was the current practice in the home.

The Assistant Administrator indicated that the home needed to evaluate and update the process related to assessments of residents at risk related to nutrition care and dietary services.

B. During the inspection, a document titled "Registered Dietitian, 02-02-06", dated February 2, 2006 and a job description titled "Consulting Registered Dietitian, 02-02-01D", dated February 2, 2001 were reviewed. The document and job description directed the home to schedule the RD to work on a regular basis at a minimum staffing level of 15 minutes per resident per month. It was confirmed the home's procedure had not been reviewed or revised to reflect the homes current practice or meet the legislative requirements as per O. Reg. 79/10, s. 74 (2), that the registered dietitian is required to be on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

C. During the inspection, the following documents were reviewed:
i) “Dietary/Nursing Communication, 04-05-06”, policy, dated April 5, 2006
ii) “Changes in Resident Weight, 04-01-05a”, procedure number dated April 1, 2005
iii) “Monitoring Fluid Intake and Dietary Referrals, 04-04-04A”, dated April 4, 2004

All three documented identified staff were to send referrals to the dietitian using a paper “Dietary/Nursing Communication” form. During the inspection, RPN #114 identified that the Nursing Department completed referrals to the dietary department/dietitian using an electronic dietary referral form. In addition to completing the electronic referral, it was common practice that registered staff would also place a call to the dietary office.

In an interview with the DOC is was shared that the home had been completing electronic referrals for over a year. It was confirmed that the three documents noted above had not been updated to reflect the home’s current referral practices. It was identified during the inspection that RD #103 was not involved in the creation or implementation of these new referral processes.

On November 20, 2019, the DOC and the Dietary Manager confirmed that the organized program of nutrition care, dietary services and hydration for the home had not been updated and evaluated at least annually in accordance with evidence-based practices. [s. 30. (1) 1.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident received fingernail care, including the cutting of fingernails.

Resident #003 was observed on an identified date and their fingernails were long, and required trimming. A second observation took place and on this observation, resident #003's nails had not yet been trimmed and six (6) fingers, and one (1) thumb had a significant amount of debris under the nails.

According to the bath schedule, resident #003 was scheduled to have received a bath or shower the day before the second observation. In an interview conducted with staff #110, it was confirmed that resident #003 received a shower on that day, however their fingernails were not trimmed. After this interview with staff #110, this staff member was observed cleaning and trimming resident #003's fingernails.

An interview was conducted with staff #109, and it was confirmed that resident #003's nails were in need of a trim and required cleaning. [s. 35. (2)]

Issued on this 5th day of December, 2019

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

Original report signed by the inspector.