Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: June 26, 2023	
Original Report Issue Date: May 31, 2023	
Inspection Number: 2023-1267-0004 (A1)	
Inspection Type: Complaint Follow up Critical Incident System	
Licensee: Heritage Green Nursing Home	
Long Term Care Home and City: Heritage Green Nursing Home, Stoney Creek	
Amended By Angela Finlay (705243)	**Inspector who Amended Digital Signature** Paola C Meyer Digitally signed by Paola C Meyer Date: 2023.06.26 16:03:50 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to reflect a change in the compliance due date for compliance order #001 from July 11, 2023, to July 25, 2023.

Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Amended Licensee Report (A1)

Amended Report Issue Date: June 26, 2023	
Original Report Issue Date: May 31, 2023	
Inspection Number: 2023-1267-0004 (A1)	
Inspection Type: Complaint Follow up Critical Incident System	
Licensee: Heritage Green Nursing Home	
Long Term Care Home and City: Heritage Green Nursing Home, Stoney Creek	
Lead Inspector Angela Finlay (705243)	**Additional Inspector(s)** Melody Gray (123)
Amended By Angela Finlay (705243)	**Inspector who Amended Digital Signature** Paola C Meyer Digitally signed by Paola C Meyer Date: 2023.06.26 16:04:08 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to reflect a change in the compliance due date for compliance order #001 from July 11, 2023, to July 25, 2023.

INSPECTION SUMMARY

The inspection occurred on the following dates:
January 9-13, 16-18, 20, 23-24, 26-27, 31, February 3 and May 1-4, 8, 10-12, 2023, was conducted on-site and January 25, 30 and May 9, 2023, was conducted off-site.

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake #00013098/ CI# 2776-000054-22 was related to alleged resident abuse.
- Intake #00017005/ CI# 2776-000059-22 was related to a medical emergency.
- Intake #00017748/ CI# 2776-000004-23 was related to falls prevention and management.

The following intakes were completed in this Complaint inspection:

- Intake #00012498 was related to resident care and support services and resident rights.
- Intake #00013419 was related to alleged resident abuse.
- Intake #00021582 was related to resident care and support services and resident rights.

The following intakes were completed in this Follow up inspection:

- Intake #00005099 was related to safe lift and transferring.
- Intake #00005453 was related to plan of care.
- Intake #00005522 was related to falls prevention and management.
- Intake #00005554 was related to resident rights.

Previously Issued Compliance Order(s)

The following previously issued Compliance Orders were found to be in compliance:
Order #001 from inspection #2021_689586_0022 related to O. Reg. 79/10, s. 30 (2), inspected by Angela Finlay (705243)

Order #002 from inspection #2021_689586_0022 related to LTCHA, 2007, s. 6 (2), inspected by Angela Finlay (705243)

Order #002 from inspection #2022-1267-0001 related to FLTCA, 2021, s. 3 (1) 2., inspected by Angela Finlay (705243)

The following previously issued Compliance Order was found **NOT** to be in compliance:
Order #001 from inspection #2022-1267-0001 related to O. Reg. 79/10, s. 36, inspected by Angela Finlay (705243)

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (5)

The licensee failed to ensure that a resident's substitute-decision maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary
In November of 2022, a registered nurse (RN) documented in the home's progress notes that a resident's SDM did not want a specific type of care to be provided.

The RN stated that they informed the SDM about the risks of this decision and the SDM accepted those risks. However, after the conversation with the SDM the resident's plan of care was not updated to reflect the SDM's wishes and staff continued to provide the care.

In January of 2023, the resident's plan of care was updated to reflect the SDM's wishes.

The home failed to implement the resident's SDM's care wishes when they failed to update the plan of care and continued to provide the care against the SDM's wishes.

Sources: The resident's clinical records, and interview with a RN. [705243]

Date Remedy Implemented: January 17, 2023

WRITTEN NOTIFICATION: Licensee must comply

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 101 (4)

The licensee has failed to comply with Compliance Order (CO) #001 from inspection #2022-1267-0001 in relation to O. Reg. 79/10 s. 36, served on August 19, 2022, with a compliance due date of October 31, 2022.

Rationale and Summary
Personal support worker (PSW) staff who worked on Cedarwood home area were educated on the safe use of the ceiling lift, according to the manufacturer's instructions AP-450 Handicare Owners Manual including the application of safety straps and using the correct sling size. However, this education was completed in February of 2023 and therefore did not meet the compliance due date of October 31, 2022.

At the time of the inspection, the remaining parts of the order not yet complied with included ensuring all of the PSW staff from Cedarwood home area completed training on what to do if they did not have the appropriate transferring devices, and the completion of a two week audit to ensure that a specific resident was being transferred using the appropriate sling size.

Sources: The specific resident's clinical records, and interviews with the Clinical Educator. [705243]

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 2.

The licensee failed to ensure that a resident's right to their lifestyle and choices, was fully respected.

Rationale and Summary
Prior to February of 2023, the home had collaborated with a resident and had a plan in place that supported the resident's right to engage in a specific lifestyle choice. In February of 2023, an incident occurred with the resident in relation to their lifestyle choice and as a result, the resident's plan of care was changed to no longer support the resident in this choice.

The resident was unhappy with this decision and stated that this was something they valued.

The DOC stated that the resident's plan of care related to the lifestyle choice was changed after the incident in February as the home felt it was too much of a safety risk to continue to support. They also stated that they had not considered or trialed any other interventions to respect the resident's right to engage in their lifestyle choice.

In May of 2023, the home reinstated the resident's ability to engage in their lifestyle choice, with an added intervention to ensure safety.

The resident's right to their lifestyle choices was not respected between February and May of 2023 when the home failed to support it without trialing other interventions or approaches.

Sources: The resident's clinical records, and interviews with the resident, the DOC, and the Administrator. [705243]

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. ii.

The licensee failed to provide a resident with the right to give or refuse consent to any treatment, care or services.

Rationale and Summary
In November of 2022, three PSWs entered a resident's room to provide care to the resident. The resident did not consent to the care. The three PSWs provided the care while the resident verbally and physically resisted.

Three PSWs and a registered practical nurse (RPN), all stated in interviews that if a resident refused care, the staff were to provide education to the resident about why the care was important and if the resident continued to refuse, staff were expected to respect the residents wishes, inform the nurse on the unit, and re-approach to provide care at another time.

Providing care to the resident when they were resistive and refused consent interfered with their rights and had the potential to cause distress to the resident.

Sources: Home's investigation into the incident, CI #2776-000054-22, the resident's clinical records, and interviews with the three PSWs, a RPN and the Director of Care (DOC). [705243]

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that a resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Rationale and Summary
The resident's plan of care stated that they were a high risk of falls but they were not a candidate for a specific falls intervention due to self-ambulation.

The resident was no longer self-ambulating.

A RN stated that the resident should have been reassessed for the falls intervention as they were no longer self-ambulating and the care plan should have been revised with the resident's current care needs.

Failing to reassess the resident's plan of care when their mobility status and needs changed, may have impacted the home's ability to reduce the risk and severity of future falls.

Sources: The resident's clinical records, and interviews with a RN and RPN. [705243]

WRITTEN NOTIFICATION: Duty to protect

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee failed to protect a resident from physical abuse by staff.

Section 2 of O. Reg. 246/22, defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain."

Rationale and Summary
In November 2022, three PSWs entered a resident's room to provide care. The staff involved stated the resident did not consent to the care and was verbally and physically resistive. The three PSWs held the resident down by their arms and legs to provide the care and this resulted in an abrasion, bruise, and skin tear to the resident.

The resident's SDM stated that the resident informed them that they had gotten into a fight with a PSW that evening and that was how they received the bruise. The resident did not want to talk about it as they were scared it would happen again.

Separate interviews with three different PSWs and a RPN all stated that staff are not to physically hold a resident down to provide care.

The PSWs using physical force to hold the resident down resulted in physical injuries to the resident.

Sources: The home's abuse policy, the home's responsive behaviours policy, home's investigation into the incident, CI #2776-000054-22, the resident's clinical records, and interviews with the three PSWs, a RPN and the Director of Care (DOC). [705243]

WRITTEN NOTIFICATION: Binding on licensees

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every Minister's Directive that applies to the long-term care home, the Minister's Directive was complied with.

In accordance with the Minister's Directive "COVID-19 guidance document for long-term care homes in Ontario," the licensee was required to ensure that all residents were assessed at least once daily for signs and symptoms of COVID-19, including temperature checks.

Rationale and Summary
On January 9, 2023, the inspector completed an audit of the last 30 days to assess completion of COVID-19 monitoring, including temperature checks. One resident from each home unit was looked at for a total of nine residents.

All of the nine residents had between two to five days of no temperature checks over the observed 30-day period.

All three units of the first floor of the home were declared in a COVID-19 outbreak on January 4, 2023. Of the three residents from these units observed, none had received temperature monitoring on January 2, 2023, two days prior to the declaration of the outbreak, and two had not received temperature monitoring on January 4, 2023, the date of the declared outbreak.

Failing to complete daily COVID-19 monitoring including temperature checks may have impaired the home's ability to detect infections and take immediate appropriate actions in order to reduce the spread of COVID-19.

Sources: The Minister's Directive titled, "COVID-19 guidance document for long-term care homes in Ontario", COVID-19 symptom monitoring records, and interviews with the IPAC lead, ADOC, and the DOC. [705243]

WRITTEN NOTIFICATION: General requirements

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee failed to ensure that any actions taken with respect to a resident under the continence care and bowel management program including interventions and the resident's responses to the interventions were documented.

Rationale and Summary
A resident informed the inspector that they had concerns with waiting long periods of time between brief changes and on several occasions had to wait up to eight hours for staff assistance.

The home had a schedule in place for the resident that included six different times throughout the day for staff to provide a brief change.

The DOC stated that it was the home's expectation that staff document that this care had been provided.

On three dates in May 2023, there was no documented provision of care related to brief changes for two of the six daily changes.

Sources: The resident's clinical record, the toileting routine binder, and interviews with the resident, a PSW and the DOC. [705243]

WRITTEN NOTIFICATION: Required programs

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee failed to ensure that the falls prevention and management program to reduce the incidence of falls and the risk of injury was implemented for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that there was a falls prevention and management program and that this program was complied with.

Rationale and Summary
A) A resident had a fall in October of 2022.

The home's falls program included a policy titled, "Falls Assessments" last reviewed on June 1, 2022. This stated that if a resident were to have a fall, a referral must be sent to the physiotherapist (PT) for further follow-up.

The Clinical Educator stated that PT referrals were completed through Point Click Care (PCC) either through the risk management section for the fall or through the progress notes. There was no referral for PT found in the progress notes or the risk management for the resident's fall they had in October of 2022.

By not referring to the PT, the resident was at risk of potentially missing interventions that could have reduced the resident's risk of future falls and injuries.

Sources: The resident's clinical records; the home's falls policy; and interviews with a RPN and the Clinical Educator. [705243]

B) A resident was found on the floor after an unwitnessed fall. They were transferred to hospital and returned about 22 hours after the fall.

The home's policy titled, "Falls Assessments," last reviewed on June 1, 2022, stated that a Head Injury Routine (HIR) assessment would be completed for any unwitnessed fall.

The home used a paper form titled, "Neurological Floor Sheet (Assessment Record) (HIR)" that stated the form should be completed following this time schedule: every 15 minutes for the first hour after the fall, every hour for the next three hours, every two hours for the next four hours, every four hours for the next 16 hours, and every eight hours for the next 48 hours. This provided for a total of 19 checks over 72 hours after the fall.

A RPN stated that staff were to complete the HIR monitoring for nine shifts post fall and that sometimes staff would document one time per shift in the progress notes as opposed to completing the 19 checks on the paper form. The Clinical Educator stated that staff could document in the progress notes as opposed to the paper form once per shift once the time schedule got to the last step of monitoring every eight hours.

There was no paper HIR form for this resident's fall. The resident's vitals were documented in the progress notes at the time of the fall and three further times upon return from hospital opposed to the seven times the HIR time schedule required.

By not completing the HIR as intended, the resident may have been at risk of a head injury not being promptly attended to.

Sources: The resident's clinical records, the home's falls policy, the home's HIR form, and an interview with a RPN and the Clinical Educator. [705243]

WRITTEN NOTIFICATION: Falls prevention and management

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident had a fall, a post-fall assessment was conducted using a clinically appropriate assessment instrument.

Rationale and Summary
A resident had a fall in October of 2022. The home was unable to produce a completed post-fall assessment for this fall.

Not completing a post-fall assessment may have impaired the home's ability to recognize any required interventions to reduce the resident's risk of falls or injury from future falls.

Sources: The resident's clinical records, the home's falls policy, and interviews with two RPN's and the DOC. [705243]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

The licensee failed to ensure that the Director was informed no later than one business day after a resident had a fall that resulted in hospitalization and a significant change in their health condition.

Rationale and Summary
A resident had a fall and was sent to the hospital. Ten days after returning from hospital, it was noted that the resident's health status had declined, and a significant change assessment was initiated.

The home reported the incident to the Director three business days after the significant change assessment was initiated.

Sources: Critical incident report #2776-000004-23, the resident's clinical records, and interviews with a PSW and a RPN. [705243]

WRITTEN NOTIFICATION: CMOH and MOH

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272

The licensee has failed to ensure that a guidance document issued by the Ministry of Health was followed in the home.

In accordance with the Ministry of Health's "COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units," the licensee was required to ensure that staff and visitors who received a positive COVID-19 test result while they were at the long-term care home left the facility immediately.

Rationale and Summary
In January of 2023, a staff member received a positive rapid antigen test (RAT) for COVID-19 as part of the home's COVID-19 asymptomatic screen testing. The staff member completed active screening at the front entrance at 0906hrs and then proceeded to complete a RAT. At 0930hrs, they attended a meeting and were informed of the positive RAT after they left the meeting.

At 1045hrs, the staff member was still present in the home. They stated that they had not left the home yet as they were waiting for a nurse to complete a polymerase chain reaction (PCR) test.

Failing to leave the home immediately after receiving a positive COVID-19 test may have placed residents and other staff at risk of infection.

Sources: Observations, the home's front screening records, Ministry of Health's guidance document titled, "COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units, and interviews with a screener, the staff member as well as the Administrator and DOC. [705243]

COMPLIANCE ORDER CO #001 Dining and snack service

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:

1. Provide education to the food service workers on the home's process for ensuring residents receive their correct diets, special needs and preferences at meals. Home to keep a documented record of what education was provided, signatures of staff who received the education, and date the education was provided.

2. Home to complete an audit to ensure that the food service workers are complying with the home's process to ensure residents are receiving their correct diets, special needs and preferences. The audit is to be done daily for a two-week period prior to the compliance due date and should include any actions taken if non-compliance is observed. Home to keep a documented record of the audit.

Grounds
The licensee failed to ensure that there was a process to ensure that food service workers and other staff assisting residents were aware of the residents' diets, special needs and preferences.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that there was a Nutritional Care and Hydration program that included a process to ensure staff were aware of the residents' diets, special needs and preferences and that this must be complied with.

Rationale and Summary
The home had binders at all of the serveries that contained a list of all of the residents on that floor that included their diets, special needs and preferences.

On January 10 and January 11, 2023, the food service workers on the second floor were observed during lunch service from the time they entered the serveries until the end of the meal service. They were not observed to review the binders at any point prior to plating the residents' meals.

The Food Service Manager (FSM) stated that the expectation was for staff to look up each resident in the binders prior to plating their meals to ensure they were being served the correct diets and that any special needs, preferences or additional adjustments were adhered to.

Failing to comply with the home's process for ensuring staff were aware of the residents' diets, special needs, and preferences placed residents at risk of receiving the incorrect diets.

Sources: Observations of second floor servery, home's Food and Nutritional Services Manual, and interview with the FSM. [705243]

This order must be complied with by July 25, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.