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

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Public Report

Report Issue Date: December 10, 2024

Inspection Number: 2024-1267-0004

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Heritage Green Nursing Home

Long Term Care Home and City: Heritage Green Nursing Home, Stoney Creek

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: November 27, 28, 29, 2024 and December 2, 3, 2024.

The following intakes were inspected:

- Intake: #00120000 related to improper/incompetent care.
- Intake: #00126651 related to improper/Incompetent treatment.
- Intake: #00127684 related to duty to protect.
- Intake: #00127875 related to duty to protect.
- Intake: #00129877 related to duty to protect.
- Intake: #00130147 related to duty to protect.
- Intake: #00131125 related to duty to protect.
- Intake: #00131628 related to falls prevention and management.
- Intake: #00129600 for a Complaint related to duty to protect and safe and secure home.
- Intake: #00126028 for Follow Up to Compliance Order #001 from Inspection #2024-1267-0003, related to FLTCA, 2021 - s. 6 (7) with a compliance due date of October 11, 2024.

The following intakes were completed:

- Intake: #00125009 related to falls prevention and management.
- Intake: #00129873 related to falls prevention and management.
- Intake: #00131549 related to falls prevention and management.

Previously Issued Compliance Order(s)

The previously issued Compliance Order was found to be in compliance:

Order #001 from Inspection #2024-1267-0003 related to FLTCA, 2021, s. 6 (7).

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that the written plans of care set out the planned care for the residents.

Rationale and Summary
A. A resident displayed responsive behaviours.

The resident had an intervention to assist in the management of their behaviours.
A review of the care plan and kardex, where Personal Support Workers (PSW) obtained information related to the care needs of a resident, did not include that the resident displayed the responsive behaviours nor the interventions.
Failure to ensure that the plan of care included the planned care for the resident had the potential for staff to be unaware of care needs.

Sources: Plan of care, Minimum Data Set (MDS) assessment, Point of Care records and electronic Medication Administration Records of a resident and interviews with staff.

Rationale and Summary
B. There was a history of responsive behaviours with two residents.
The electronic Medication Administration Record for a resident included an intervention in an effort to manage the behaviour.
A review of the resident's written plan of care and kardex, where PSWs obtained information related to the care needs of a resident, did not include the intervention.
There was the potential for behaviours with the residents when the care plan and kardex, accessible by PSW staff, did not include the intervention.

Sources: A report; a resident's clinical record; interviews with staff.

Rationale and Summary
C. A resident had a history of responsive behaviours.
An intervention was implemented on two separate occasions.
A review of the resident's written plan of care and kardex, where PSWs obtained information related to the care needs of a resident, did not include that the intervention was implemented.
Failure to ensure that the plan of care included the implementation of the intervention had the potential for staff to be unaware of care needs.

Sources: Reports; a resident's clinical record; interviews with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary
The plan of care for a resident identified the level of assistance required for an activity of daily living.
A staff member provided the activity of daily living with a different level of assistance than set out in the plan of care.
Staff failed to provide care as set out in the plan of care and as a result the resident was involved in an incident.

Sources: Progress notes and plan of care of a resident; investigative notes; and interviews with staff.

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was revised when the care set out in the plan was no longer necessary.

Rational and Summary
Documentation included a resident's request to complete care with a different level of staff assistance, than previously required.
Staff approached the resident to provide care as previously required; however, the care had already been completed in accordance with the request of the resident.
The care plan had not been updated to reflect the current care needs and still included the previous level of assistance required.
By not having the plan of care revised with the resident's current care needs staff were unaware of the resident's change in care needs.

Sources: Observation of a resident; resident's care plan; interviews with staff and a resident.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning

techniques when they assisted a resident.

Rationale and Summary
A resident's plan of care identified a level of assistance with transfers.
Staff completed a transfer with a different level of assistance than specified in the plan of care.
Failure to ensure that staff used safe transferring and positioning techniques when they assisted a resident increased their risk for injury and harm.

Sources: A resident's plan of care; a report; interview with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident received a skin assessment, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, when they had an area of altered skin integrity.

Rationale and Summary
A resident had a new area of altered skin integrity.
There was no initial assessment of the area of altered skin with a clinically

appropriate assessment instrument that was specifically designed for skin and wound, when it was first discovered.
Failure to complete a timely initial skin assessment had the potential for the staff not to know if the area of altered skin integrity worsened.

Sources: A resident's clinical record; Skin Care Program; interviews with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(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.

The licensee has failed to ensure that for each resident who demonstrated responsive behaviours, actions taken to respond the needs of the resident, including reassessments, were documented.

Rationale and Summary
A resident had a history of responsive behaviours and an intervention was implemented.
The intervention was later discontinued after the resident was reassessed.
There was no documentation in the resident's clinical record of the reassessment when it was determined that the intervention was no longer required.
Failure to document the reassessment of the resident had the potential for staff to be unaware of the care needs of the resident, and any new interventions or

strategies.

Sources: A report; a resident's clinical record; interviews with staff.