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: January 16, 2024
Original Report Issue Date: January 4, 2024
Inspection Number: 2023-1267-0007 (A1)
Inspection Type: Complaint Critical Incident (CI) Follow-up
Licensee: Heritage Green Nursing Home
Long Term Care Home and City: Heritage Green Nursing Home, Stoney Creek

Amended By	**Inspector who Amended Digital Signature**
Sydney Withers (740735)	Sydney Withers Digitally signed by Sydney Withers Date: 2024.01.16 17:15:12 -05'00'

AMENDED INSPECTION SUMMARY

This inspection report has been amended to change the compliance due date for compliance orders (CO) #001, #002 and #003 and to amend the content of CO #002.

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 (A1)

Amended Report Issue Date: January 16, 2024	
Original Report Issue Date: January 4, 2024	
Inspection Number: 2023-1267-0007 (A1)	
Inspection Type: Complaint CI Follow-up	
Licensee: Heritage Green Nursing Home	
Long Term Care Home and City: Heritage Green Nursing Home, Stoney Creek	
Lead Inspector Sydney Withers (740735)	**Additional Inspector(s)** Adiilah Heenaye (740741) Emma Volpatti (740883) Stephanie Smith (740738)
Amended By Sydney Withers (740735)	**Inspector who Amended Digital Signature** Sydney Withers Digitally signed by Sydney Withers Date: 2024.01.16 17:15:29 -05'00'

AMENDED INSPECTION SUMMARY

This inspection report has been amended to change the compliance due date for compliance orders (CO) #001, #002 and #003 and to amend the content of CO #002.

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: November 21, 23-24, 27-30 and December 1, 4, 2023.

The following intakes were inspected:

- Intake 00019662/ CI #2776-000005-23 was related to late reporting of a resident to resident altercation;
- Intake 00020609/ CI #2776-000010-23 was related to neglect;
- Intake 00089176 was a follow-up related to transferring and positioning techniques;
- Intake 00090064/ CI #2776-000034-23 was related to improper/ incompetent care of a resident;
- Intake 00096379/ CI #2776-000038-23 was related to a fracture of unknown etiology;
- Intake 00097701/ CI #2776-000042-23 was related to falls prevention and management;
- Intake 00099427 was related to concerns with falls prevention and management;
- Intakes 00100045 and 00100557 were related to concerns with transferring and positioning techniques; and
- Intake 00100044/ CI #2776-000044-23 was related to a resident injury.

Previously Issued Compliance Orders

The following previously issued Compliance Order was found to be in compliance:
Order #001 from Inspection #2022-1267-0001 related to O. Reg. 79/10 s. 36, inspected by Emma Volpatti (740883)

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Falls Prevention and Management

AMENDED 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)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for two residents set out clear directions for staff and others who provided direct care to the residents.

Rationale and Summary
A) A resident's written plan of care indicated that they were to have a specific fall intervention in place at all times. During the inspection, the resident was observed to

have a different type of intervention in place. A registered practical nurse (RPN) and personal support worker (PSW) confirmed that the written plan of care did not give clear directions to staff related to the intervention the resident was to have in place.

Registered nursing staff revised the plan of care during the inspection reflect the specific intervention in use for the resident.

Sources: Resident observation, resident clinical record, interviews with staff. [740741]

Date Remedy Implemented: November 23, 2023

B) A second resident's written plan of care required staff to ensure they had a specific fall intervention in place. During the inspection, the resident was observed to have a different type of intervention in place. A registered nurse (RN) acknowledged that the direction for staff related to the intervention was not clear.

During the inspection, the plan of care was revised to reflect the intervention in use.

Sources: Resident observation, resident clinical record, interviews with staff. [740735]

Date Remedy Implemented: November 27, 2023

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

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,

(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for a resident set out clear directions for staff and others who provided direct care to the resident.

Rationale and Summary

A resident's written plan of care required staff to document whether or not a fall intervention was in place, but did not provide any direction for staff regarding the intervention. The resident was observed without the fall intervention in place during the inspection. An RN and the Clinical Educator were unable to determine from the resident's written plan of care whether they required the intervention.

Failure to provide clear direction to staff in the written plan of care led to staff uncertainty regarding the falls interventions required for the resident.

Sources: Resident observations, resident clinical record, interviews with RN and Clinical Educator. [740735]

WRITTEN NOTIFICATION: Integration of Assessments, Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

Plan of care

Integration of assessments, care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that the staff involved in the different aspects of a resident's care collaborated with each other in the assessment of the resident so that their assessments were integrated and consistent with each other.

Rationale and Summary
A resident had a fall which was not reported to registered nursing staff. A few days later, a PSW identified that the resident had an area of altered skin integrity and documented their observation. The following day, the resident was hospitalized, and an injury was identified.

The PSW indicated that they informed registered nursing staff of the altered skin integrity when they observed it. The RPN who allegedly received the report indicated they were not made aware of the altered skin integrity, therefore no skin and wound assessment was completed.

When direct care and registered nursing staff failed to ensure their assessments of the resident were integrated and consistent with each other, the resident did not receive the assessments or care which may have been clinically indicated.

Sources: Resident clinical record, investigation records, interviews with staff. [740735]

WRITTEN NOTIFICATION: Documentation

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

Plan of care

Documentation

s. 6 (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care set out in multiple residents' plan of care was documented.

Rationale and Summary

A) A resident required a personal assistance service device (PASD) for positioning and assistance with their activities of daily living (ADL). Staff were expected to document care at a specified interval while the resident was using the PASD. The task created related to the resident's PASD did not populate the system where PSWs documented care. An RN acknowledged that provision of care related to the PASD should have been documented by staff and that there was no history of documentation available.

Sources: Resident clinical record, interview with RN. [740735]

B) A resident's plan of care directed staff to turn and reposition them at a specified frequency. There was no task available for staff to document care related to turning and repositioning, therefore no documentation was completed. An RN acknowledged that the task was not available in for staff to document care.

Sources: Resident clinical record, interview with RN. [740735]

C) Review of a resident's plan of care showed gaps in documentation of care. Staff did not document provision of care related to falls interventions, repositioning or safety checks on several occasions.

Sources: Resident clinical record; interview with the Assistant Director of Care (ADOC). [740741]

D) A resident's plan of care directed staff to complete safety checks at a specified frequency. A review of their plan of care indicated that safety checks were not being documented by staff. The ADOC acknowledged that staff should have been documenting the safety checks under a task, and that there was no task available for staff to document this care.

Sources: Resident clinical record, interview with the ADOC. [740883]

E) A resident's plan of care indicated they were to be turned and repositioned at a specified frequency. Review of the resident's clinical record indicated staff were not documenting provision of this care. The ADOC acknowledged that this care should have been documented by staff.

Sources: Resident clinical record, interview with the ADOC. [740883]

WRITTEN NOTIFICATION: Specific Duties Re Cleanliness and Repair

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
Specific duties re cleanliness and repair
s. 19 (2) Every licensee of a long-term care home shall ensure that,

(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has failed to ensure that equipment was maintained in a good state of repair.

Rationale and Summary
During the inspection, a resident's fall intervention device was tested and no sound was noted. A PSW stated the device should sound when activated, as it was used as a fall prevention intervention for the resident. Registered nursing staff identified that the device was not connected to the main unit, due to the main unit being broken, and acknowledged that the device was not maintained in a good state of repair.

Failure to ensure that the resident's device was maintained in a good state of repair put the resident at risk for harm or injury.

Sources: Resident room observations, interviews with staff. [740883]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that an incident of improper care of a resident that

resulted in harm to the resident was immediately reported to the Director.

Rationale and Summary
On a specified date, a resident was transferred using an incorrect lift which resulted in pain and an exacerbation of the resident's health condition. The LTCH submitted a report to the Director one week following the date of the incident.

The Director of Care (DOC) acknowledged the incident should have been reported immediately to the Director and it was not.

Sources: Resident clinical record, CI #2776-000034-2023, LTCH's investigation notes, interview with the DOC. [740883]

WRITTEN NOTIFICATION: Conditions of License

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (3)
Conditions of licence
s. 104 (3) It is a condition of every licence that the licensee shall comply with this Act, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

The licensee has failed to ensure that they complied with the agreement made under the Connecting Care Act, 2019.

Specifically, the licensee did not complete a Resident Assessment Instrument - Minimum Data Set (RAI-MDS) Significant Change in Status Assessment for two residents within the required timeframes.

Rationale and Summary

A) The Long-Term Care Home Service Accountability Agreement (LSAA) entered into pursuant to the Connecting Care Act, 2019 with the Health Service Provider (HSP) required the licensee to conduct assessments of residents as per the RAI-MDS Tools, using the RAI-MDS Tools.

The home was to complete a significant change in status assessment as soon as needed to provide appropriate care to the individual, but in no case, later than 14 days of determining a significant change occurred. A "significant change" is defined as a major change in the resident's status that is not self-limiting, impacts more than one area of the resident's health status and requires interdisciplinary review and/or revision of the care plan. A condition is defined as “self-limiting” when the condition will normally resolve itself without further intervention or by staff implementing standard disease-related clinical interventions.

A resident exhibited a medical condition and change in status in the home on a specified date and was transferred to the hospital, where they were diagnosed with a fracture. Re-admission assessments completed at the LTCH indicated that the resident had changes to more than one area of their health status whereby the plan of care was revised.

The ADOC acknowledged that a significant change RAI-MDS assessment was not completed following the resident's return to the LTCH and that the resident's change in status met the definition of a significant change as per the RAI-MDS 2.0 User's Manual.

Not completing a significant change RAI-MDS assessment may have impacted the timely and accurate assessment of the resident’s care needs.

Sources: Resident clinical record; Service Accountability Agreement with Heritage Green Nursing Home; RAI-MDS 2.0 User's Manual; Interview with the ADOC. [740741]

B) A second resident fell and sustained an injury which required surgical intervention. When they returned to the LTCH, they experienced changes to more than one area of their health status whereby their plan of care was revised.

A review of the resident's RAI-MDS assessments indicated there was no significant change RAI-MDS assessment completed. The ADOC acknowledged that the resident met the requirements for a significant change, and an assessment should have been completed accordingly.

Sources: Resident clinical record, RAI-MDS 2.0 User's Manual, Canadian Version, February 2012, LSAA April 2023 to March 2024, interview with the ADOC. [740883]

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)
General requirements
s. 34 (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.

The licensee has failed to ensure that any actions taken with respect to a resident under the nursing and personal support services program, including assessments, were documented.

Rationale and Summary
A resident had a fall which was not reported to registered nursing staff. Several days following the fall, a PSW was providing support to the resident, identified changes to the resident's condition and reported their observations to registered nursing staff.

The RPN acknowledged that they assessed the resident and identified a change in the resident's status. Documentation by the RPN did not detail their assessment findings or include a referral indicated by the concerns they identified. The ADOC acknowledged that the RPN did not document a complete nursing assessment related to the resident's change in status.

When the RPN did not fully document their nursing assessment, there was a risk that the resident may not have received appropriate care or follow-up from staff.

Sources: Resident clinical record, interviews with staff. [740735]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
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,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee has failed to ensure that a resident received immediate treatment and

interventions to promote healing and prevent infection of a wound.

Rationale and Summary
A resident fell and sustained fracture which required surgical intervention. Upon returning to the LTCH, the resident had a surgical wound. The clinical record did not include a treatment for the surgical wound or an assessment of the wound, specifically, measurement of the wound, a description of the wound or where the wound was located. The ADOC acknowledged that there was no treatment initiated or specific assessment for the surgical wound.

Failing to provide immediate treatment and interventions for the resident's surgical wound posed a risk of wound deterioration and possible exposure to infection.

Sources: Resident clinical record, CI #2776-000042-23, interview with the ADOC. [740883]

WRITTEN NOTIFICATION: Pain Management

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, they were assessed using a clinically appropriate assessment instrument specifically designed for pain.

Rationale and Summary
A resident complained of pain for multiple days and was receiving as needed pain medication to manage the pain. Their clinical record indicated that there was no pain assessment completed during that time period.

The home's policy indicated that the tool titled Pain Assessment for Cognitively Alert Resident should be completed as needed when a resident complains of pain or demonstrates signs of pain.

The DOC acknowledged that this tool was not completed for the resident during the period where they complained of pain.

Failing to complete a pain assessment for the resident put them at risk of unmanaged pain.

Sources: Resident clinical record, the home's policy titled "Pain Assessment", last reviewed May 30, 2023, interview with the DOC. [740883]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #011 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 a resident:
A) Monitoring of their behaviour using the home's Dementia Observation System (DOS) was fully documented; and
B) Actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions related to their responsive behaviours.

Rationale and Summary
A) DOS documentation was started for a resident following an incident of responsive behaviour. The DOS Collection Sheet was missing documentation for an entire day within the five-day observation period.

The DOC acknowledged that the DOS Collection Sheet was incomplete.

Failure to fully complete the DOS Collection Sheet posed a risk of the resident's responsive behaviours that may have required follow-up, not being identified.

Sources: Resident's DOS Collection Sheet, interview with the DOC. [740738]

B) The resident had a responsive behaviour involving another resident. In the CI report submitted to the Ministry of Long-Term Care (MLTC), the home indicated that both residents would have a referral sent to Behaviour Support Ontario (BSO) to assess both resident's' responsive behaviours.

The resident's records were reviewed and no BSO referral was sent. The DOC acknowledged that a BSO referral was not completed for the resident.

Failure to ensure that actions were taken to respond to the resident needs, including a BSO assessment, put the resident at risk of increased unmanaged responsive

behaviours.

Sources: Resident's paper chart, interview with the DOC. [740738]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that every verbal complaint made to the licensee or a staff member concerning the care of a resident was investigated.

Rationale and Summary
Investigation records indicated that the ADOC was made aware of a concern regarding the care of a resident by registered nursing staff. The concern demonstrated potential for harm or risk of harm to one or more residents. Interviews with the DOC and ADOC acknowledged that an investigation should have been completed and was not done.

Failure to investigate a concern that demonstrated potential for harm or risk of harm to a resident posed an ongoing risk to the resident.

Sources: Investigations records, interviews with staff. [740735]

WRITTEN NOTIFICATION: Medication Management System

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to ensure that a written policy within their medication management system was implemented.

Rationale and Summary
A) Registered nursing staff documented the administration of pain medication in a resident's progress notes. The progress note indicated the medication was given for pain at a specified pain score with pending effect. There was no follow-up pain level progress note identified in the resident's clinical record.
The home's medication administration policy and an interview with the ADOC indicated staff were required to document medication administration on the medication administration record (MAR). They also confirmed that entry of a pain medication on medical directive on the MAR prompts registered nursing staff to describe the effect of the medication on the resident's pain in a progress note.

Failure of registered nursing staff to document medication administration on the MAR may have led to administration of the medication in excess of the directions for use in the medical directive. By not creating a MAR entry, registered nursing staff were not prompted to reassess the resident's pain level following medication

administration.

Sources: Resident clinical record, policy #4.07 "Administering Medications" (reviewed August 18, 2023), interview with the ADOC. [740735]

B) Registered nursing staff documented administration of two doses of antibiotics in a resident's progress notes. The home's medication administration policy required staff to document medication administration on the MAR. The resident received an excess of two doses of this medication. The ADOC acknowledged that medication administration was to be documented on the MAR.

Failure of registered nursing staff to document medication administration on the MAR may have led to administration of the medication in excess of the directions for use by the prescriber.

Sources: Resident clinical record, policy #4.07 "Administering Medications" (reviewed August 18, 2023), interview with the ADOC. [740735]

WRITTEN NOTIFICATION: Administration of Drugs

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that a drug was administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

A physician order was signed for a resident to receive an antibiotic for five days. Medication administration documentation in the progress notes and the MAR indicated that the resident received the medication for six days. The ADOC acknowledged that the resident received the antibiotic for one day longer than the directions for use specified.

There was risk associated with the resident receiving a drug in excess of what the directions for use specified.

Sources: Resident clinical record, physician order, interview with the ADOC. [740735]

(A1)

The following non-compliance(s) has been amended: NC #015

COMPLIANCE ORDER CO #001 Duty of Licensee to Comply with Plan

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

Duty of licensee to comply with plan

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

The licensee shall:

1. Perform weekly audits on two residents for four weeks to ensure a specified fall intervention is applied at the frequency described in their plan of care, unless the resident has refused. Document the audits, including the names of staff who completed each resident audit, outcomes of the audit and any corrective actions taken based on audit results.
2. Perform weekly audits on a resident for four weeks to ensure their fall intervention is in good working order when in place as per their plan of care. Document the audits, including the names of staff who completed each audit, outcomes of the audit and any corrective actions taken based on audit results.
3. Educate all PSWs who work in a specified resident home area (RHA) on the expectation for documenting care related to falls interventions in POC, including but not limited to the expectation on what staff are to document

under a task in POC to indicate the intervention has been applied or refused. Maintain documentation of the content of education provided, date and staff attendance.

Grounds
The licensee has failed to ensure that the care set out in the plan of care was provided to two residents as specified in their plans related to falls interventions.

Rationale and Summary
A) A resident was at risk of falls and required the use of a fall intervention at all times. The resident's intervention was not in place during an observation by the inspector, which was confirmed by a PSW. An RPN acknowledged that the resident was to have the intervention in place at all times.

Failure to ensure the fall intervention was in place for the resident increased their risk of injury.

Sources: Resident observation, resident clinical record, interviews with staff. [740735]

B) The same resident had a fall on a specified date. According to the resident's plan of care at the time of their fall, they required the use of a fall intervention at all times. Documentation of care on the date of their fall and an interview with a PSW present during the fall confirmed that the resident did not have the required intervention in place at the time of their fall. An RPN acknowledged that the resident required the use of the intervention at all times.

Failure to ensure the fall intervention was in place for the resident at the time of their fall increased their risk of injury.

Sources: Resident clinical record, interviews with staff. [740735]

C) A second resident's plan of care indicated they were to have a fall prevention intervention in place at all times. Their plan of care also stated that at times, the resident refused for the intervention to be in place. During the inspection, the resident was observed in their room without the fall intervention in place. A PSW acknowledged the intervention was not in place and it should have been. Review of the resident's clinical record for that day did not indicate the resident refused for the intervention to be in place.

Failing to ensure that the care set out in the plan of care was provided to the resident posed a risk of potential harm or injury to the resident.

Sources: Resident observations, resident clinical record, CI #2776-000042-23, interviews with staff. [740883]

D) The same resident had a fall on a specified date. An investigation by the LTCH determined that that the resident's fall prevention intervention was not functioning at the time of their fall. A review of the resident's plan of care at the time of the fall indicated that staff were to ensure the intervention was in good working condition when in use. The ADOC acknowledged that the intervention should have been working.

Failing to ensure that the care set out in the plan of care was provided to the resident posed a risk of potential harm or injury to the resident.

Sources: Resident observations, resident clinical record, CI #2776-000042-23, interviews with staff. [740883]

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

This order must be complied with by
March 15, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
Prior non-compliance with LTCHA s. 6 (7) resulting in a CO in inspection 2021_560632_0004, issued March 15, 2021.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.
Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

(A1)

The following non-compliance(s) has been amended: NC #016

COMPLIANCE ORDER CO #002 Transferring and Positioning Techniques

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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

The licensee shall:

1. Perform weekly audits for four weeks to ensure three randomly selected residents on a specified RHA are transferred using the method and level of staff assistance as per their plan of care. Maintain documentation of the following:
    a. Names of staff who completed each audit;
    b. Outcomes of the audit; and
    c. Any corrective actions taken based on audit results.
1. Perform weekly audits for four weeks to ensure a specified resident is transferred using the mechanical lift and level of staff assistance as per their plan of care. Maintain documentation of the following:
    a. Names of staff who completed each audit;

b. Outcomes of the audit; and

c. Any corrective actions taken based on audit results.

Grounds
The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting four residents.

Rationale and Summary
A) On a specified date, two PSWs were transferring a resident during personal care. A PSW began to use a specified lift to transfer the resident, when the resident complained of pain and verbalized the correct lift was not being used. The PSW stopped the transfer and used a different lift to finish transferring the resident.

Review of the resident's clinical record indicated they required a specified lift for all transfers. Additionally, the resident complained of pain following the transfer, was sent to the hospital for further evaluation with resulting exacerbation of a health condition.

The DOC acknowledged that staff did not transfer the resident using the lift required by the resident, therefore resulting in an unsafe transfer.

Failing to transfer the resident safely caused actual harm to the resident.

Sources: Resident clinical record, LTCH's investigation notes, CI #2776-000034-2023, interviews with staff. [740883]

B) On a specified date, a second resident had a fall with two PSWs present. One of the PSWs indicated that the resident was transferred from the floor to their bed

using a mechanical lift immediately after the fall, prior to assessment by registered nursing staff.

The home's falls prevention policy directed staff to assess the resident for injury prior to transferring them off the floor using a mechanical lift. An RPN confirmed that when the PSWs transferred the resident to bed without a nursing assessment, this was an unsafe transfer.

When direct care staff transferred the resident without a nursing assessment, this posed a risk of injury to the resident.

Sources: Resident clinical record, policy #09-02-01 "Falls Prevention" (reviewed June 1, 2023), interviews with staff. [740735]

C) A review of investigation records during the inspection identified a concern related to resident transfers on a specified date. Inspectors 740735, 740738 and 740883 reviewed video surveillance on the specified date and observed a PSW moving a mechanical lift and resident into a resident room. Shortly after, a member of the home's registered nursing staff was observed to enter the room.

Investigation records and an interview with the observed RPN indicated that the PSW was observed transferring a resident in the same room using the mechanical lift without a second staff member. The PSW confirmed the resident they were providing care to at the time of the video surveillance in an interview with inspector 740735. A review of the resident's plan of care demonstrated that they required two staff assistance using the mechanical lift for the care observed by the RPN on the specified date. The DOC and Administrator acknowledged that this was an unsafe transfer.

When direct care staff used an unsafe transferring technique, a third resident was at risk of injury and discomfort during care.

Sources: Resident clinical record, investigation records, video surveillance, interviews with staff. [740735]

D) A review of investigation records during the inspection identified a concern related to resident transfers on a specified date. Inspectors 740735, 740738 and 740883 reviewed video surveillance on a specified date and observed a PSW moving a mechanical lift and resident into a resident room. Over a 23-minute period, the PSW was observed completing care activities, before moving the same resident and mechanical lift out of the room. No other staff members were observed entering or exiting the resident room when care was provided to the resident.

The PSW confirmed the resident they were providing care to at the time of the video surveillance in an interview with inspector 740735. A review of the resident's plan of care demonstrated that they required two staff assistance using the mechanical lift for the care observed on the specified date. The DOC and Administrator acknowledged that this was an unsafe transfer.

When the direct care staff used an unsafe transferring technique, a fourth resident was at significant risk of injury and discomfort during care.

Sources: Resident clinical record, investigation records, video surveillance, interviews with staff. [740735]

This order must be complied with by
March 15, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #002
Related to Compliance Order CO #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
Prior non-compliance with O. Reg 79/10 s. 36 resulting in a CO in inspection 2022-1267-0001, issued August 19, 2022.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.
Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

(A1)

The following non-compliance(s) has been amended: NC #017

COMPLIANCE ORDER CO #003 Falls Prevention and Management

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 54 (2)

Falls prevention and management

s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

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

The licensee shall:

1. Educate all PSWs on the definition of a fall, including the home's definition of an assisted fall, and actions to take when they are present or witness a resident who has fallen. Maintain documentation of the content of education provided, date and staff attendance.

Grounds

The licensee has failed to ensure that when a resident fell, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary

On a specified date, two PSWs were transferring a resident using a mechanical lift following care. During the transfer, the resident began removing their body from the lift, sustaining altered skin integrity in the process, and were lowered to the floor by the PSWs. An RPN was informed of the altered skin integrity by one of the PSWs and an initial skin and wound assessment was completed. The same PSW indicated they were asked by the RPN if the resident had fallen and they responded the resident had not fallen. Several days later, the resident exhibited a new area of altered skin integrity and pain, was sent to hospital, where a fracture was identified.

The home's falls prevention policy defined a fall as an event that resulted in a person coming to rest inadvertently on the ground, floor or other lower level. Interviews with the two involved PSWs confirmed that the resident was lowered to the floor from the mechanical lift. The ADOC acknowledged that a post-fall assessment should have been completed following the resident's fall and that it was not done since registered nursing staff was not made aware a fall had occurred.

As a result of the fall not being reported to registered nursing staff, additional post-fall assessments and referrals were not processed. A transfer assessment was not completed for the resident following their fall. According to investigation records, the resident continued to be transferred by staff using the same lift used prior to the fall over a four-day period. The resident's plan of care was revised to remove the use of the mechanical lift one week following the fall.

Failure for direct care staff to report the fall to registered nursing staff led to the resident not receiving care and services consistent with their needs, and posed a risk of discomfort during care.

Sources: Resident clinical record, CI #2776-000044-23, investigation records,

policy #09-02-01 "Falls Prevention" (reviewed June 1, 2023), interviews with staff. [740735]

This order must be complied with by
March 15, 2024

COMPLIANCE ORDER CO #004 Reporting Certain Matters to Director

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with FLTCA, 2021, s. 28 (1) 2. [FLTCA, 2021, s. 155 (1) (b)]:
The licensee shall prepare, submit and implement a plan to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

The plan must include but is not limited to:

1. Revision of the home's process for internal investigations to include submission of a CI report to the Director prior to commencing the investigation, then amending the CI accordingly as required.
2. Auditing to evaluate the home's reporting of all incidents applicable under FLTCA, s. 28 (1) 2., including who will be responsible for auditing, when it will be completed and what follow-up actions will be taken when reporting is not completed as required. Documentation must be maintained for the LTC Inspector to review.

Please submit the written plan for achieving compliance for inspection #2023-1267-0007 to Sydney Withers (740735), LTC Homes Inspector, MLTC, by email by January 18, 2024.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds
The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, immediately reported the suspicion and the information upon which it was based to the Director. Pursuant to s. 154 (3), the licensee was vicariously liable for staff members failing to comply with s. 28 (1).

Rationale and Summary
A) A resident's Substitute Decision Maker alleged neglect to an RPN on a specified date. The alleged neglect was regarding an area of the resident's care.

The following day, an RN documented that an allegation of neglect was made and at that time reported the allegation to the MLTC's after-hours reporting line.

The home's Zero Tolerance for Abuse and Neglect Policy, indicated that staff must immediately report every alleged, suspected or witnessed incident of neglect of a resident by the licensee, a staff member (or affiliate) of the Home, and to immediately report to the appropriate supervisor in the home on duty (or on call) at the time of the alleged incident. The RPN stated that they did not report the allegation of neglect to anyone and acknowledged that any incident of neglect or abuse should be reported immediately.

Failure to report an allegation of neglect immediately to the Director put the resident at risk for harm or neglect.

Sources: Resident progress notes, CI: 2776-000010-23, Zero Tolerance for Abuse and Neglect Policy (last reviewed June 3, 2023), interview with RPN. [740738]

B) On a specified date, a resident grabbed another resident's personal belonging. The resident whose belonging was grabbed became upset and a physical responsive behaviour occurred. Staff intervened and separated the residents. There was no injury to the resident who received the physical responsive behaviour.

A CI report was submitted to the MLTC approximately six hours after the incident occurred as indicated on the CI.

An RPN confirmed they were aware of the MLTC's reporting guidelines and stated that the process was for them to inform the charge RN whom then reports to Management or calls the MLTC's after-hours reporting line. The RPN stated that Management were in the home and aware of when the incident happened.

The DOC acknowledged that incidents of suspected or alleged abuse or neglect should be immediately reported to the Director.

Failure to report potential abuse immediately to the Director put residents at risk for harm or abuse.

Sources: CI: 2776-000005-23, interviews with staff. [740738]

C) Review of human resources (HR) records and a resident's clinical record demonstrated an alleged incident of staff to resident verbal abuse on a specified date. Documentation indicated that the resident directed insulting remarks at the PSW, who responded with derogatory words toward the resident.

The DOC indicated that an investigation commenced after the on-call manager received a report of the alleged incident from registered nursing staff. Based on the investigation, abuse was not substantiated, and a CI was not submitted to the MLTC.

Failure to report suspected abuse to the Director may have placed residents at risk of harm.

Sources: HR records, resident clinical record, interview with the DOC. [740735]

This order must be complied with by
February 14, 2024

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.