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

Ottawa District
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Original Public Report

Report Issue Date: February 6, 2024

Inspection Number: 2023-1046-0006

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Heartwood Operating Inc.

Long Term Care Home and City: Heartwood, Cornwall

Lead Inspector	**Inspector Digital Signature**
Heath Heffernan (622)	Heath Heffernan Digitally signed by Heath Heffernan Date: 2024.02.12 09:50:43 -05'00'

Additional Inspector(s)
Jessica Nguyen (000729)
Shevon Thompson (000731)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 12, 15, 18-22 and 27-29, 2023.

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

- Intake: #0095994/CI# 2088-000024-23 related to respiratory outbreak.
- Intake: #0096030/CI# 2088-000025-23 related to alleged staff to resident sexual abuse.
- Intake: #0096774/CI# 2088-000026-23 related to alleged staff to resident physical abuse.
- Intake: #0099874/CI# 2088-000029-23 related to alleged staff to resident verbal/emotional abuse.

- Intake: #0100225/CI# 2088-000030-23 related to alleged resident neglect/abuse by staff.
- Intake: #0100598/CI# 2088-000031-23 related to alleged resident neglect/abuse by staff.
- Intake: #0102034/CI# 2088-000033-23-related to a fall with injury resulting in a significant change in condition.
- Intake: #0102092/CI#2088-000035-23 related to an improper transfer/lift of a resident by staff.
- Intake: #0103014/CI#2088-000036-23 related to an improper transfer/lift of a resident by staff.

The following intake(s) were completed in this complaint inspection:

- Intake: #00098156 was related to fall prevention and management and continence care.
- Intake: #00101373 was related to fall prevention and management.

The following intake was completed in this follow up inspection:

- Intake: #00099759 -Follow-up #: 1 - O. Reg. 246/22 - s. 40- Order related to transferring and positioning techniques. Compliance due date (CDD) December 8, 2023.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1046-0005 related to O. Reg. 246/22, s. 40 inspected by Heath Heffernan (622)

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

Resident Care and Support Services

Continence Care
Infection Prevention and Control
Prevention of Abuse and Neglect
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)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
When reassessment, revision is required
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 the plan of care for a resident was reviewed and revised when the resident's care needs changed and the resident's falls risk was increased, the resident required the use of a mechanical aid and two staff assistance

for transferring, toileting and the use of a specified piece of fall prevention equipment when in bed and wheelchair.

Rationale and Summary

On December 12, 2023, Inspector observed a logo above the resident's bed indicating that the resident required two staff and the use of a mechanical aid for transfers. A Personal Support Worker (PSW) affirmed that the resident used specified fall prevention equipment which was moved from the bed to the wheelchair when the resident was up. The PSW confirmed that the resident required two staff and a mechanical aid for transferring.

A review of the resident's plan of care on a date in December 2023, indicated that the resident was at specific risk for falls, transferring and toileting assistance had not been updated to include the use of the specified number of staff or a mechanical aid for transfers. The Inspector was also unable to find any interventions for the use of the specified piece of fall prevention equipment.

A review of the resident's plan of care, with interventions created one day after the inspector's previous review date in December 2023, indicated that the resident's plan of care had been updated to include the higher level of fall risk, the interventions of a mechanical aid with the assistance of the two staff for transferring and toileting and the use of the specified piece of fall prevention equipment when in bed and the wheelchair.

A PSW confirmed that the resident's plan of care had not been updated to reflect the increase in the resident's fall risk, the requirement of two staff and a mechanical aid for transferring, toileting and the specified piece of fall prevention equipment after the resident returned from the hospital following a fall.

A Registered Practical Nurse (RPN) affirmed that new interventions would be updated in the plan of care. The RPN confirmed that interventions that were seen in the resident's room on the logo board would be expected to have been added to the plan of care whenever the new interventions were introduced as part of the resident's care. The RPN validated that the registered staff was expected to update the plan of care when the resident's care needs change.

The Assistant Director of Care (ADOC) confirmed that the resident had a significant change in physical status on return from the hospital and required the use of a mechanical aid and two staff for assistance with transfers. The ADOC also confirmed there was a specified piece of fall prevention equipment put in place after the fall. The ADOC validated that the home's expectation, when a resident's care need had changed and new interventions were implemented, was for the plan of care to be updated immediately. The ADOC validated that the interventions observed by the Inspector in the resident's room on the date in December 2023, should have been added to the resident's plan of care, when the interventions had been initiated upon the resident's return from hospital.

Sources: Observations of the resident's room, review of the resident's electronic health record, interviews with a PSW and other staff.
[000731]

Date Remedy Implemented: December 14, 2023

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that a person who had reasonable grounds to suspect that staff to resident abuse had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary
Critical Incident System report (CIS) #2088-000029-23 was related to alleged staff to resident abuse of a resident on a date in October 2023, that was reported to the Director two days after the occurrence.

During an interview a Personal Support Worker (PSW) stated that on a specified date in October 2023, a resident alleged that a PSW had been abusive to them on a specified date two days earlier in October 2023. The PSW stated that they reported the allegation to the Registered Nurse (RN) and a Registered Practical Nurse (RPN) during their shift that date in October 2023.

During separate interviews the RN stated that they had not reported the allegation of abuse of the resident by a PSW to the Director. The RPN stated that they gave direction for the reporting PSW to document and submit the allegation to the Director of Care for follow up.

During an interview the Executive Director (ED) stated that the allegation of staff to resident abuse of the resident by the PSW should have been immediately reported to the Director by the RN on the specified date in October 2023, when they became

aware of the allegation.

Sources: Review of the CIS #2088-000029-23 and interview of a PSW and other staff.
[622]

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that the care set out in the plan of care specifically related to transferring and positioning techniques was provided to a resident as specified in the plan.

Rationale and Summary
On a date in November 2023, two Personal Support Workers (PSWs) were observed by the Office manager transferring a resident using a mechanical aid. According to the resident's care plan document, they were to use a different specified mechanical aid with two person assist for all transfers.

During an interview with a PSW, they confirmed that they always transferred the resident using the mechanical aid that they were observed using on the date in November 2023. They did not check or follow the resident's plan of care when they used the wrong mechanical aid when transferring the resident with another PSW.

The Executive Director (ED) stated that the home's investigation determined that the two PSWs performed an improper transfer and did not follow the resident's plan of care. ED confirmed that according to resident's plan of care including: the care plan document, the Kardex and the logo posted in the resident's room, the resident needs to use the specified mechanical aid with two person assist for all transfers and that the resident's plan of care was not followed.

By not ensuring that the resident's plan of care was followed and that the resident was transferred using the specified mechanical aid with two person assist, the resident was placed at an increased risk for injury due to the improper lift.

Sources: Review of the resident's plan of care (care plan, Kardex and SALT logo), Interview with a PSW and other staff.
[000729]

WRITTEN NOTIFICATION: Duty to protect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was not neglected by staff.

Rationale and Summary
In accordance with O. Reg 246/22, s. 7. For the purposes of the Act and this Regulation, “neglect” means the failure to provide a resident with the treatment,

care, services, or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Review of the licensee's investigation notes dated on a specific date in October 2023, indicated that during interviews with a Personal Support Worker (PSW) and Director of Care (DOC), they stated that the resident had been checked on that specified date in October 2023. According to the PSW, the resident had been incontinent and the bed was still soiled.

Review of the licensee's investigation notes dated on a specified date in November 2023, indicated that a PSW informed the DOC that there had been no care given to the resident on the shift prior to the two PSWs observing the resident's incontinence on the specified date in October 2023.

The home's investigation notes dated on the specified date in October 2023, indicated that a Registered Nurse (RN), informed the Executive Director (ED) that the resident required complete care including a bed change.

In an interview with a PSW, they confirmed that on the specified date in October 2023, they had observed the resident who was incontinent and had not been changed during the previous shift.

In an interview with the ED, they confirmed that the incident of alleged neglect of the resident, on the specified date in October 2023, was substantiated during the home's internal investigation. The ED affirmed that the resident was not provided care during the shift and did not receive care for approximately 11 hours.

Failure to provide care for the resident leaves the resident at risk for issues including the potential for skin breakdown.

Sources: Review of the home's investigation notes and interview with a PSW and other staff.
[000731]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

1) The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents has been complied with.

Rationale and Summary
According to the licensee's POLICY ADMIN1-010.02 - Resident Non-Abuse - LTC - Investigation of Abuse or Neglect, reviewed on July 31, 2016, the priority is to ensure the safety and comfort of the abuse victim(s) by taking steps to provide for their immediate safety and well being, then complete full assessments to determine the Resident's needs and document them on the Resident's plan of care.

On a specified date in October 2023, a Personal Support Worker (PSW) reported to

a Registered Nurse (RN) and a Registered Practical Nurse (RPN), that a resident alleged a PSW was abusive to them two days earlier.

A review of the progress notes dated on the specified date in October 2023, indicated that the Director of Care (DOC) had interviewed and assessed the resident for safety and comfort when they became aware of the allegation of abuse by the PSW. There was no documentation to support that an assessment of the resident's safety and comfort was completed by the RN or RPN when they became aware of the allegation approximately seven hours earlier.

During separate interviews, the RN and RPN stated that they had not assessed the resident for safety and comfort on the specified date in October 2023, when the PSW reported the allegation of abuse of the resident by the PSW.

By not assessing the resident's well-being at the time that an allegation of abuse was reported, may result in a negative outcome to the resident.

Sources: Review of the licensee's policy ADMIN1-010.02, the progress notes and interview with the RN and other staff.
[622]

2) The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with.

Rationale and Summary
Specific to the licensee's policy #ADMIN1-010.02 - Resident Non-Abuse - LTC - Investigation of Abuse or Neglect, reviewed on July 31, 2016, indicated that anyone who suspects that abuse or neglect of a resident has occurred, must immediately report that information to the Executive Director or, if unavailable, to the most senior

supervisor on shift.

Critical Incident System report (CIS) #2088-000025-23 was related to alleged Personal Support Worker (PSW) to a resident abuse which allegedly occurred on a date in August 2023, and was submitted to the Director on a date six days later.

During an interview, the Executive Director (ED) stated that during an interview for an unrelated incident, the PSW alleged that an incident of staff (PSW) to a resident abuse had occurred six days earlier on a date in August 2023.

Failure to report suspected abuse as directed in the licensee's policy can increase the risk of harm or injury to the resident.

Sources: Review of the CIS report and interview with the ED and other staff.
[622]

WRITTEN NOTIFICATION: Reporting certain matters to the 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 the improper or incompetent treatment or

care of a resident that resulted in harm or a risk of harm to the resident was immediately reported to the Director.

Rationale and Summary
Critical Incident System report (CIS) #2088-000035-23 was related to improper or incompetent treatment of a resident by two Personal Support Workers (PSWs) when they used a different mechanical aid to transfer the resident rather than using the mechanical aid which had been specified for the resident. The incident was witnessed on a date in November 2023, by the home's management and was submitted to the Director four days later.

During an interview, Executive Director (ED) confirmed that the improper transfer performed by the two PSWs was witnessed on the date in November 2023, and was not reported to the Director until four days later.

Failing to immediately notify the Director of the improper or incompetent treatment of a resident, places the resident at risk of additional harm.

Sources: Review of the CIS report #2088-000035-23 and interview with the ED and other staff.
[000729]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #007 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 two Personal Support Workers (PSWs) used safe transferring and positioning techniques when assisting a resident.

Rationale and Summary
On a date in November 2023, two PSWs entered a resident's room to find the resident on the floor. Prior to a nurse assessing the resident for injuries, the PSWs assisted the resident into bed by performing a two person manual lift instead of using a full mechanical lift.

According to the home's Safe Resident Handling Skills Checklist: Transfer/Lift/Repositioning: Assisting a resident from the floor, if a resident is unable to assist themselves to a crawl/or all fours position after a fall, a full mechanical lift is to be used.

The Executive Director (ED) stated that the home's investigation determined that the two PSWs had performed an improper manual lift on the resident because they felt it was more practical and efficient than going to retrieve the equipment for the full mechanical lift. The ED confirmed that according to the home's policy the resident would require a full mechanical lift after sustaining a fall and that the two PSWs should have used the full mechanical lift to assist the resident from the floor.

By not ensuring that the resident was transferred using a full mechanical lift with two person assist, the resident was placed at an increased risk for injury due to the improper lift.

Sources: Review of the resident's care plan document, Safe Resident Handling Skills Checklist: Transfer/Lift/Repositioning: Assisting a resident from the floor, and

interview with the ED and other staff.
[000729]

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (a)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

The licensee has failed to ensure that a resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

Rationale and Summary
On a date in October 2023, a resident was found incontinent of both of urine and stool by staff at the start of their shift and it was alleged that staff on the previous shift had not provided continence care to the resident.

Review of the resident's electronic chart indicated that there was no direction in the Kardex or interventions in place in the care plan document related to continence care or toileting needs for the resident. Review of the most recent continence assessment indicated that the resident was continent at the time of the assessment. Review of the MDS assessment- Question H1a: Continence self-control, indicated that significant changes occurred in the resident's continence in October 2022 and September 2023.

At the time of inspection, review of the resident's paper chart did not show a three-day continence diary that was to be completed by front line staff at the time of significant change, review of the resident's electronic chart did not show a continence assessment that was to be completed by registered staff at the time of significant change and review of the resident's care plan document indicated it was not updated to reflect the significant change, and did not show any interventions or direction for incontinence care or toileting needs for the resident.

During interviews with a Registered Practical Nurse (RPN) and Assistant Director of Care (ADOC), it was explained that when a resident has a change in their continence status, the front line staff should fill out a paper three day continence diary, this diary along with a form is filled out and given to the ward clerk who inputs information into the electronic care plan. The registered staff then take the information and complete a continence assessment in Point Click Care. The RPN and ADOC confirmed that none of these steps were completed, and the care plan document was not updated for the resident at the time of significant change and at time of interview still did not show any direction or interventions related to continence care or toileting needs.

By not ensuring that a continence assessment was completed and that the care plan was updated accordingly at the time of the resident's significant change in

condition, the resident was placed at higher risk of not being provided the proper continence care and toileting assistance they required.

Sources: Review of the resident's plan of care including: the care plan, paper chart, electronic record and interviews with the RPN and other staff.
[000729]

WRITTEN NOTIFICATION: Continence care and bowel management

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee has failed to ensure a resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented.

Rationale and Summary
On a date in October 2023, a resident was found incontinent of both of urine and stool by staff at the start of their shift and it was alleged that staff on the previous shift had not provide continence care to the resident.

Review of the MDS assessment- Question H1a: Continence self-control, indicated that significant changes occurred in the resident's continence in October 2022 and September 2023. Each time there was a change in the resident's continence status, an individualized plan should be created, new interventions implemented to meet the continence needs of the resident and the care plan updated accordingly.

Review of the MDS Assessment (quarterly assessment) indicated that the resident was responding to interventions outlined in the care plan document. Care plan goals and interventions had been reviewed by the care team members and continued to be effective in preventing, improving, and maintaining the identified problem. At the time of inspection, review of the resident's electronic chart showed there was no individualized plan created or implemented related to continence care or toileting needs for the resident.

During an interview with the Assistant Director of Care (ADOC), it was confirmed that the resident's continence status had changed, and no individualized plan was created or implemented, and no interventions were in place in the plan of care related to continence care or toileting needs.

By not ensuring that the resident had an individualized plan to promote and manage bladder and bowel continence, the resident was placed at a higher risk of not being provided the proper continence care or toileting assistance they required.

Sources: Review of the resident's electronic chart and interview with the ADOC. [000729]

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