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: May 7, 2024
Inspection Number: 2024-1046-0002
Inspection Type: Complaint Critical Incident
Licensee: Heartwood Operating Inc.
Long Term Care Home and City: Heartwood, Cornwall

Lead Inspector	**Inspector Digital Signature**
Maryse Lapensee (000727)	Maryse C Lapensee Digitally signed by Maryse C Lapensee Date: 2024.05.08 10:34:31 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 29, 30, 2024 and May 1, 2, 3, 2024

The following intake were completed in this complaint inspection:

- Intake: #00114339 - related to alleged staff to resident abuse.

The following intake(s) were inspected during this Critical Incident (CI) inspection:

- Intake: #00111266/CI #2088-000027-24 - related to environmental hazard that caused an injury to a resident.
- Intake: #00111888 /CI #2088-000029-24 - related to alleged resident to resident sexual abuse.
- Intake: #00114242/CI #2088-000034-24 - related to alleged staff to resident physical and emotional abuse.

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

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours

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: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the infection prevention and control (IPAC) standard issued by the Director was followed. Specifically related to additional precautions including point-of-care signage indicating that enhanced IPAC control measures are in place.

Rationale and Summary
On April 29, 2024, inspector #000727 observed an apron of Personal Protective Equipment (PPE) on the door of a room on a specific wing. There was no precaution signage posted on the door.
A Personal Support Worker (PSW) and the IPAC Lead confirmed that a resident in that room was on contact precautions.
On April 30, 2024, inspector #000727 observed a contact precaution sign on the door of a room on the specific wing.

Sources: Observations, interview with a PSW and the IPAC Lead. [000727]

Date Remedy Implemented: April 30, 2024

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 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.

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

Rationale and Summary

Specific to the licensee's policy #ADMIN1-P10 - Resident Non-Abuse, indicating that anyone who suspects that abuse or neglect of a resident has occurred, must immediately report that information to the Executive Director (ED) or, if unavailable, to the most senior supervisor on shift.

On a specific date in April 2024, a Personal Support Worker (PSW) was reporting to a Registered Practical Nurse (RPN) an allegation of verbal abuse of a PSW toward a resident. Both staff members witnessed the PSW poking the resident's head. The incident was reported to the Ministry After Hours line six hours after the incident happened.

The PSW confirmed that the RPN realized hours later that they needed to inform the ED and report the abuse to the Ministry.

The ED acknowledged that the RPN reported the allegation of abuse at a specific time to the Director of Care (DOC) and the ED, several hours after the incident happened. The ED confirmed that the RPN didn't follow the home's resident non-abuse policy when they didn't report immediately the allegation of abuse.

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 licensee's policy ADMIN1-P10, the progress notes, Ministry After hour report and interview with a PSW and the ED. [000727]

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 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 take actions to respond to a resident's responsive behaviours by ensuring that resident's responses to interventions and reassessments were documented.

Rationale and Summary:
Behavioral Support Ontario (BSO) data collection sheet, Dementia Observation System (DOS) mapping was initiated on a specific date in March 2024, at a specific time for a resident who was exhibiting new sexual responsive behaviours. There were no documented DOS mapping entries during a specific timeframe on a specific date in March 2024, and on a specific shift on three specific dates in March 2024.

According to the Responsive Behaviours Procedure (CARE 3.010.02) when a resident is exhibiting new responsive behaviours staff are to:
-Initiate Behaviour Tracking Tool for resident (BSO-DOS)
-Ensure there is documentation every shift for 3 days.

Two Personal Support Workers (PSW) confirmed that it is the responsibility of the

PSW to complete the BSO-DOS mapping documentation on every shift.

A Registered Practical Nurse (RPN) and the Assistant Director of Care (ADOC) confirmed that the PSW's are responsible for the documentation of the BSO-DOS mapping document, and the registered staff were responsible to initiate it. Both the RPN and the ADOC acknowledged that the expectation for the BSO-DOS mapping was to be completed on every shift. The RPN and the ADOC confirmed that the BSO-DOS mapping document for the resident that was initiated on a specific date in March 2024, and was not completed on specific shifts in March 2024.

As such, not documenting the responsive behaviours on the BSO-DOS document may have potentially put the resident at risk of improper assessment.

Sources: DOS mapping, a resident's health records, Responsive Bahaviours Procedure (CARE 3.010.02), Interview with PSWs, RPN and ADOC. [000727]