Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 9, 2019	2019_575214_0026	014151-18, 017307-18, 022646-18, 013347-19, 014574-19	Critical Incident System

Licensee/Titulaire de permis

Heritage Green Nursing Home
353 Isaac Brock Drive STONEY CREEK ON L8J 2J3

Long-Term Care Home/Foyer de soins de longue durée

Heritage Green Nursing Home
353 Isaac Brock Drive STONEY CREEK ON L8J 2J3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

CATHY FEDIASH (214), DARIA TRZOS (561), ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 30, 31, August 1, 2, 6, 7, 8, 12, 13, 14, 15, 16, 2019.

This inspection was conducted simultaneously with complaint inspection 2019_575214_0025 / 018599-18, 032379-18, 004874-19.

The following intakes were completed during this Critical Incident System (CIS) inspection:
014151-18- related to falls prevention and management

017307-18- related to falls prevention and management

022646-18- related to falls prevention and management

013347-19- related to falls prevention and management

014574-19- related to falls prevention and management

PLEASE NOTE: A Written Notification (WN) related to O. Reg. 79/10, r. 8 (1)(b) and r. 30 (2), was identified in this inspection and has been issued in Inspection Report #2019_575214_0025 / 018599-18, 032379-18, 004874-19, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with Administrator; Director of Care (DOC); Assistant Director of Care (ADOC); Registered staff; Personal Support Workers (PSW); housekeeping staff and residents.

During the course of the inspection, the inspector(s) reviewed CIS reports; resident clinical records; policies and procedures; staff training records; program evaluations and observed residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

1 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure the resident being reassessed and the plan of care being revised because care set out in the plan had not been effective, different approaches had been considered in the revision of the plan of care.

A Critical Incident was submitted to the Ministry of Long Term Care (MOLTC) on an identified date, that identified resident #009 had a fall that resulted in injury and a significant change in the resident's health status.

Clinical records were reviewed for resident #009 and indicated that the resident had two previous falls, that resulted in injury. The plan of care for the resident indicated that the resident was at risk for falls and used a specified mobility device. The resident had an identified safety device on their mobility device as an intervention to reduce the risk of falls. The plan of care indicated that resident was able to remove the identified safety device.

On an identified date, MOLTC Inspector #561 observed resident #009 in their room at which time they were not using their mobility device. The specified safety device had not activated and was not identified to be with the resident.

Interviews with PSWs confirmed that resident did not always use their mobility device and were able to remove their specified safety device.

RN #124 was interviewed and stated that resident #009 had identified responsive behaviours in relation to the use of their safety device and mobility device. The RN stated that the home had a different identified safety device and this was one intervention that could be tried for this resident. The RN was not sure why this was not considered.

The interview with ADOC confirmed that the specified safety device currently in use was not an effective intervention for resident #009 as they were able to remove it. The ADOC stated that a different, identified safety device had not been trialed for this resident.

The ADOC and a lead for a specified program in the home were also interviewed and confirmed that the different, identified safety device was one intervention that could be considered for this resident.

The licensee failed to ensure that different approaches had been considered in the revision of the plan of care for resident #009. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

Issued on this 24th day of September, 2019

[redacted]

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.