Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Mar 10, 2021	2021_560632_0003	010642-20, 014127-20, 016671-20, 019774-20, 024154-20	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

YULIYA FEDOTOVA (632), EMMY HARTMANN (748)

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): January 21, 22, 25, 26, 27, 28, February 1, 2, 3 and 4, 2021.

The following Critical Incident System (CIS) intakes were completed:
log #010642-20 - related to prevention of abuse and neglect, skin and wound,
log #014127-20 - related to medication,
log #016671-20 - related to falls prevention,
log #019774-20 - related to skin and wound, nutrition and hydration, dining observations,
log #024154-20 - related to prevention of abuse and neglect.

The following Complaint Inspection #2021_560632_0004 was completed concurrently with this CIS Inspection :
log #012504-20 - related to prevention of abuse and neglect, skin and wound,
log #019434-20 - related to skin and wound, resident charges.

During the course of the inspection, the inspector(s) spoke with the Administrator, Staff Development Co-ordinator /Assistant Director of Care (ADOC) #1, Clinical Co-ordinator /ADOC#2, Physician #1, Physician #2, Food Service Manager, Ward Clerk #1, Ward Clerk #2, Activity, Wound Care Nurse, Pharmacist, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Physiotherapist, Personal Support Workers (PSWs), Housekeeper and an Infection Control Public Health Inspector.

During the course of the inspection, the inspector(s) reviewed clinical records, policies, procedures, and practices within the home, reviewed meeting minutes, observed the provision of care and medication administration.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

- **3 WN(s)**
- **2 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 O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (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. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's safety checks were documented.

The resident's written plan of care identified interventions which included safety checks initiated in an identified month in 2019. A review of their Point of Care (POC) task identified that there was no documentation of the safety checks in an identified month in 2019.

A RPN indicated that checks were completed on residents by both RPNs and PSWs, but the documentation for checks were completed by PSWs on the POC. ADOC #2 identified that safety checks had been completed since they were implemented, however, they were not documented.

Sources: resident #002's care plan, POC task; interviews with RPN #119 and ADOC #2. [s. 30. (2)]

2. The licensee failed to ensure that the resident's safety checks were documented.

The resident's written plan of care identified interventions which included safety checks initiated in an identified month in 2019. Their POC task identified no documentation of the safety checks in an identified month in 2019.

A RPN indicated that checks were completed on residents by both RPNs and PSWs, but the documentation for checks were completed by PSWs on the POC. ADOC #2 verified that safety checks were completed for the resident, but not being documented in the POC.

Sources: resident #009's care plan, POC task; interviews with RPN #119 and ADOC #2. [s. 30. (2)]

3. The licensee failed to ensure that the resident's safety checks were documented.

The resident's progress notes identified that on an identified date in 2020, the resident had a change in their health status.

The resident's written plan of care identified specified safety checks and positioning of safety equipment used for the resident at a specified period of time.

The POC identified missing documentation on an identified date in 2020.

Interview with an RPN identified that they worked on a specified shift on an identified date in 2020 and they completed the resident's specified assessment. The RPN indicated that safety checks were completed on residents by both RPNs and PSWs, but the documentation for checks was completed by PSWs on the POC.

A PSW identified that they worked on a specified shift on identified dates in 2020 and that the safety checks were completed on the resident.

ADOC #2 acknowledged that the documentation for the resident's specified safety checks was missing for the identified dates.

Sources: resident #003's progress notes, care plan, POC tasks; interviews with PSW #125, RPN #119 and ADOC #2. [s. 30. (2)]

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 and ensuring that the resident's safety checks are documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

**s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

Findings/Faits saillants :

1. The licensee failed to ensure that the home had a dining and snack services that included, at a minimum, the following elements: 10. Proper techniques to assist the resident with eating, including safe positioning of the resident who required assistance.

Review of the resident’s written care plan indicated interventions to provide specified assistance with eating. During the inspection, it was observed that the home’s staff was specifically located beside the resident while providing assistance with eating. Review of the home’s Resident Feeding Procedure indicated specified directions on providing the assistance with eating to the residents.

A RPN confirmed that the staff was to be specifically located beside the resident, when assistance with feeding was provided.

The resident was at specified risk as a result of an unsafe feeding technique.

Sources: resident #001's written care plan, Resident Feeding Procedure; interview with RPN #121. [s. 73. (1) 10.]

2. The licensee failed to ensure that the resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

The resident's written care plan indicated to provide specified assistance with eating. A review of the resident's progress notes identified that the resident received their identified meal without the assistance, which resulted in altered skin integrity. The resident's Skin and Wound Assessment identified altered skin integrity.

Interview with a PSW indicated that no other staff was with the resident at the time when the specified meal was provided to the resident. ADOC #1 indicated that if the resident required specified assistance with eating, the staff should not put anything on the table until they were ready to assist the resident.

The resident's skin integrity was altered as a result of the resident not receiving the specified assistance with meals.

Sources: resident #001's progress notes, written care plan, the Skin and Wound Assessment; interviews with PSW #120 and ADOC #1. [s. 73. (2) (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 and ensuring that the home has a dining and snack services that include, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who requires assistance and the resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the infection prevention and control program included measures to prevent the transmission of infections.

During the inspection, the home was not in outbreak and it was observed that three identified rooms were on contact precaution protocol. There were no masks and face shields and/or masks with the attached face shields and no disinfection wipes observed near or inside the identified resident’s rooms available for staff to use at point of care. The disposal bin was observed not being inside or near one of the identified rooms.

Review of the home’s Infection Control Document - Transmission Based Precautions - Contact Precautions Guidelines indicated that gowns were to be removed and discarded in laundry or garbage bag before leaving the resident's room and masks were to be used by following "Standard Precautions".

Interview with the various staff members indicated that staff were to change their masks and sanitize their face shields at the nursing station. Interview with the Infection Control Public Health Inspector identified that staff was expected by the Public Health Unit to doff at point of care where masks and face shields were to be removed in or outside the resident's room. All Personal Protective Equipment (PPE) staff needed, should have been accessible outside the room.

The residents were at risk of potentially contracting an infection as a result of the infection prevention and control measures not being accessible at point of care.

Sources: the Infection Control Document - Transmission Based Precautions - Contact Precautions Guidelines; interviews with Housekeeper #103, PSW #108, RPN #109 and RPN #112, the Infection Control Public Health Inspector. [s. 86. (2) (b)]

Issued on this 15th day of March, 2021

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

Original report signed by the inspector.