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

Hamilton Service Area Office
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Modified Public Report (M)

Report Issue Date August 19, 2022
Inspection Number 2022-1267-0001
Inspection Type
☐ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other

Licensee
Heritage Green Nursing Home

Long-Term Care Home and City
Heritage Green Nursing Home, Stoney Creek

Inspector who Amended

Barbara Grohmann (#720920)

Inspector who Amended Digital Signature
Barbara Grohmann
2022.09.20 09:16:21 -04'00'

MODIFIED PUBLIC INSPECTION REPORT SUMMARY

This public inspection report has been revised to reflect an extension compliance plan for CO #002 and an extension of the compliance due dates for CO #001 and CO #002. The Complaint, and Follow-Up inspection, 2022-1267-0001 was completed on July 7, 2022.

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 16-17, 20, 22, 24, 27-30, July 4-7, 2022

The following intake(s) were inspected:

- Intake # 016423-21 (Complaint) related to resident care and food and nutrition.
- Intake # 003037-22 (Complaint) related to alleged abuse and food and nutrition.
- Intake # 012000-22 (Complaint) related to falls and temperatures.
- Intake # 001102-22 (Complaint) related to falls, alleged abuse, pain management, food and nutrition, resident care, and resident rights.

- Intake # 004474-21 (Follow-up) related to personal hygiene and plan of care.
- Intake # 013949-21 (Follow-up) related to plan of care.
- Intake # 013950-21 (Follow-up) related to falls prevention and management.

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Previously Issued Compliance Order(s)

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

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
LTCHA, 2007	s. 6 (7)	2021-560632-0004	001	Cynthia DiTomasso (#528)

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
O. Reg. 79/10	s.30 (2)	2021-689586-0022	001	Cynthia DiTomasso (#528)
LTCHA, 2007	s. 6 (2)	2021-689586-0022	002	Cynthia DiTomasso (#528)

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

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Medication Management
- Pain Management
- Palliative Care
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Safe and Secure Home

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#XX remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 6(1)(c)

The licensee has failed to ensure that the written plan of care for resident #002 set out clear directions to staff and others who provided direct care to the resident.

The written plan of care for resident #002 identified that the resident preferred a specific activity of daily living on certain days and times of the week. The schedule for the identified activity of daily living and the Point of Care (POC) documentation listed the activity happening on different days and times. PSW #119 and RPN #120 confirmed that the resident recently their changed their requested days.
RPN #120 updated resident #002's written plan of care to reflect the correct days.

Sources: care schedules, written plan of care, Point of Care, interviews with RPN #120 and PSW #119.

Date Remedy Implemented: June 17, 2022 [#528]

WRITTEN NOTIFICATION – LICENSING

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 101(4)

The licensee has failed to comply with Compliance Order (CO) #001 from Inspection #2021_689586_0022 served on August 27, 2021, with a compliance due date of November 25, 2021.

Rationale and Summary
The monthly Fall Committee Meeting minutes did not include all residents who had fallen.

The documentation in the respective residents' clinical health records of the multidisciplinary post-fall huddle after each fall was not completed, as post-falls huddles were not being completed consistently. Residents' plans of care were not updated to reflect changes discussed at the falls committee meetings.

Sources: CO #001 from #2021_689586_0022, Falls Committee meeting minutes, interviews with DOC #101 and other staff, clinical health records for resident #002 and resident #028. [#528]

WRITTEN NOTIFICATION – LICENSING

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

Non-compliance with: LTCHA, 2007 s. 101(4)

The licensee has failed to comply with Compliance Order (CO) #002 from Inspection #2021_689586_0022 served on August 27, 2021, with a compliance due date of November 25, 2021.

Rational and Summary
The records provided by the home did not include any documentation to support that the home had reviewed processes, policies and/or procedures for physiotherapy (PT) and occupational therapy (OT) referrals.

Re-education was not provided to all registered staff on the processes; and a documented record was not kept.

Sources: CO #001 from #2021_689586_0022, the home's September 2021 compliance action plan, Management and restorative meeting minutes, training record, interviews with DOC #101 and ADOC #127. [#528]

WRITTEN NOTIFICATION – PLAN OF CARE

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

Non-compliance with: LTCHA, 2007 s. 6(4)(a)

The licensee has failed to ensure that staff and others involved in the different aspects of care of resident #005 collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

Rationale and Summary
Resident #005 was readmitted from the hospital with multiple areas of altered skin integrity. An admission assessment identified multiple areas of altered skin integrity.
A week later, a skin and wound assessment completed by registered staff identified that skin was intact.
Registered staff #145 confirmed that the skin and wound assessments were not consistent with nor complemented each other, in relation to identifying areas of altered skin integrity.

Sources: resident #005's clinical health records, skin and wound assessments, interview with registered staff #145. [#528]

WRITTEN NOTIFICATION – PLAN OF CARE

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

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

The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #002 collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

Rationale and Summary
Resident #002 was admitted to the home in 2018. The clinical health record identified the resident had a symptom. The medication administration record included a treatment for the identified symptom. A few weeks later, a referral was sent and completed by a consultant for resident #002, for the identified symptom. Recommendations included pharmacological and non-pharmacological interventions.
The Medication Administration Record identified that the resident continued to have the symptom.
The clinical health record and ADOC #127 confirmed that the physician had not seen the consultation notes and recommendations several weeks after it was completed. The interdisciplinary team did not collaborate with each other in the development and implementation of the resident's ongoing identified symptom.

Sources: resident #002's clinical health record, interview with registered staff #127, interviews with BSO SW #125 and ADOC #127. [#528]

WRITTEN NOTIFICATION – PLAN OF CARE

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6(5)

The licensee has failed to ensure that resident #002 was given an opportunity to participate fully in the development and implementation of their plan of care.

Rationale and Summary
The plan of care for resident #002 identified that the resident identified directions to staff.

For several months the resident was documented as reporting concerns to staff that their plan of care did not reflect their wishes; however, the home continued to follow the plan of care.
Interview with DOC #101 confirmed that the home was following the resident's plan of care, which was based on incomplete documents and not the resident's wishes.
The home failed to respond to resident #002's ongoing concerns which was documented as having a negative impact on the resident.

Sources: resident #002's clinical health records, Power of Attorney documents, interviews with ADOC #102 and DOC #101. [#528]

WRITTEN NOTIFICATION – PLAN OF CARE

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

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

The licensee has failed to ensure the care set out in the plan was provided to resident #002 as specified in the plan.

Rationale and Summary
A. The plan of care for resident #002 identified directed staff to place the call bell within reach.

The resident was observed in their room and the call bell was not with their reach.

Interview with PSW #119 confirmed that the call bell was not within the resident's reach as specified in the plan of care.

Sources: resident #002's clinical health records, observation, interview with PSW #119. [#528]

The licensee failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan.

Rationale and Summary
B. The plan of care for resident #002 identified that a certain amount of staff were to be present for care. On an identified day, the resident reported concerns. The home's investigation and ADOC #102 confirmed that the number of staff identified in their plan of care, were not present.

Sources: resident #002's clinical health records, customer concern form, interviews with PSW #130 and ADOC #102. [#528]

The licensee has failed to ensure that the plan of care was provided to resident #005 as specified in the plan.

Rational and Summary
C. Resident #005 was readmitted to the home with a significant change with new orders. Progress notes included complaints from the family in relation to the new orders not being followed. Registered staff #127 confirmed that the plan of care was not followed.

Sources: resident #005's clinical health records, interviews with registered staff #127 and other staff. [#528]

WRITTEN NOTIFICATION – PLAN OF CARE

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6(10)(c)

The licensee has failed to ensure that resident #002 was reassessed and the plan of care reviewed and revised when care set out in the plan had not been effective.

Rationale and Summary
Resident #002 was admitted to the home and provided with a mobility device. On an identified day, an assessment was completed of the resident and identified that the device was not the right size, and a new device was requested and delivered. Four months later, the device was supplied to the resident, but the resident refused to use it.
The resident continued to complain of specific issues with the old device.

Interview with staff could not identify any other revisions to the plan of care in relation to their ongoing old device complaints, after the resident refused to use the new device.

The home failed to review and revise the plan of care when the resident refused to use their new device, the resident continued to express discomfort with the old device.

Sources: resident #002's clinical health records, interviews with ADOC #102 and 127, interview with PSW #119, interview with OT, interview with Hauser sales representative. [#528]

WRITTEN NOTIFICATION – SAFE AND SECURE HOME

NC#008 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 24(2)2

The licensee has failed to ensure that the temperatures were measured and documented in writing in one resident common area on every floor.

Rationale and Summary
The long-term care home had nine home areas on three floors, three per floor.

Temperature logs were provided from the home did not include common temperatures for one home area.

The maintenance manager explained that due to a software issue, temperatures for the identified area were overwritten after one week. The software installer was working on resolving the issues.

Failure to maintain temperature documentation for a resident common area in every floor of the home may have impaired the home's ability to monitor temperature trends and adjust where necessary.

Sources: temperature logs, emails and interview with the Maintenance Manager. [#720920]

WRITTEN NOTIFICATION – GENERAL REQUIREMENTS FOR PROGRAMS

NC#009 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 30(2)

The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions, and the resident's responses to interventions were documented.

Rational and Summary

Resident #005 required assistance of staff with specific care at several times a day. The home's policy directed staff to document care in Point of Care (POC). Review of POC documentation for two months did not include documentation on each occasion that the care was completed.

PSW #147 and #130 confirmed that staff provided assistance and ADOC #127 confirmed that care was to be documented in POC.

Sources: resident #005's clinical health records, interviews with staff, home's policy [#528]

WRITTEN NOTIFICATION – REQUIRED PROGRAMS

NC#010 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 49(2)

The licensee has failed to ensure that when resident #002 fell, the resident was assessed and a post-fall assessment was conducted using a clinically appropriate assessment tool, specifically designed for falls.

Rationale and Summary

On an identified date in December 2021, resident #002 fell.

Review of the plan of care did not include a post-fall assessment using a clinically appropriate assessment tool specifically designed for falls. RN #136 and ADOC #102 confirmed that the resident was not assessed using a clinically appropriate assessment tool specifically designed for falls.

Sources: resident #002's clinical health records, interviews with registered staff #136 and ADOC #102. [#528]

WRITTEN NOTIFICATION – REQUIRED PROGRAMS

NC#011 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 50(2)(b)(iv)

The licensee has failed to ensure that a resident exhibiting altered skin integrity was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Rationale and Summary

Resident #002 was readmitted to the home with areas of altered skin integrity. The plan of care did not include a weekly assessment of the all the identified areas the following week. ON two occasions, assessments were completed on some of the areas, but did not identify the area of altered skin integrity; and therefore, was unable to determine which location was assessed

Registered staff #145 identified that the wound care nurse completed the weekly wound assessments; however, was unable to locate assessments for the missing weeks.

Failure to complete weekly wound assessments for resident #005, placed the resident at risk for further skin breakdown.

Sources: resident #005's clinical health records, skin and wound assessments, interview with registered staff #145, Skin Care Program 05-07-01, dated May, 2021. [#528]

WRITTEN NOTIFICATION – REQUIRED PROGRAMS

NC#012 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 53(2)

The licensee has failed to ensure that the falls prevention and management program to reduce the incidence of falls and the risk of injury provided for assessment and reassessment instruments.

O. Reg 242/22 s.11(1)(b) requires the organized program to be complied with.

Specifically, the home's Falls Prevention Program, Falls Assessment Policy, dated June 1, 2022, was not complied with as follows:

- head injury routine was not completed for 72 hours following a fall with a head injury.

Rationale and Summary
On an identified day, resident #004 fell and sustained a superficial head injury and required further assessent. When the resident returned the following day, the head injury routine (HIR) was not started for several hours. ADOC #102 confirmed that the HIR was not completed as required in the Falls Assessment Policy, dated June 1, 2022.

Sources: resident #004's clinical health records, interview with ADOC #102, the home's Falls Assessment Policy, dated June 1, 2022. [#528]

WRITTEN NOTIFICATION – NUTRITION CARE AND HYDRATION PROGRAMS

NC#013 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 76(3)(c)

The licensee has failed to ensure that the full-time cook completed a food handler's training program as evidenced by a valid food handler's certificate.

Rationale and Summary
Cook #141's food handler's certificate had an expiry date of October 27, 2019. The cook acknowledged that they had not completed the food handler's training program, receiving a certificate with an expiry date after 2019.

The dietary manager confirmed that cook #141 was the full-time cook and that they had not received an updated food handler's certificate despite several requests and reminders.

Failure to have up to date credentials had the risk of staff being unaware of any changes or updates in safe food handling practices since their last training program.

Sources: food handler's certificates; interviews with the Dietary Manager and other staff. [#720920]

WRITTEN NOTIFICATION – NUTRITION CARE AND HYDRATION PROGRAMS

NC#014 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 78(2)(g)

The licensee has failed to ensure that any menu substitutions were documented on the production sheet.

Rationale and Summary

The home's Menu Substitution Form detailed that the cook was responsible for documenting any substitutions on the corresponding production sheet. Cook #112 stated that they have a substitution binder where that information was documented.

- June 17, 2022, a menu substitution was posted for dinner in the second and third floor dining rooms.
- June 20, 2022, a substitution occurred for dessert at lunch and dinner on the second floor.
- June 22, 2022, a menu substitution was posted for lunch in the second and first floor dining rooms.
- June 24, 2022, a menu substitution was posted for lunch in the second and third floor dining rooms.

The substitution binder did not contain any documented substitutions for 2022. The dietary manager acknowledged that the binder was the only place substitutions would be documented and if it was not in the binder, it was not done. Cook #141 stated that they did not know that substitutions were to be documented in the binder or anywhere else, other than the slips that are posted on the dining room menus.

Failure to document menu substitutions prevented the dietary manager from monitoring substitutions and potentially reducing the frequency.

Sources: observations; substitution binder, Menu Substitution Form (no date); interviews with the Dietary Manager and other staff. [#720920]

WRITTEN NOTIFICATION – NUTRITION CARE AND HYDRATION PROGRAMS

NC#015 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with s. 73(1)5 of O. Reg. 79/10 under the Long-Term Care Homes Act, 2007 and s. 79(1)4 of O. Reg. 246/22 under the FLTCA

The licensee has failed to ensure that they had a process to ensure food service workers and other staff assisting residents were aware of the residents' diets, special needs, and preferences.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 73(1)5 of O. Reg. 79/10. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 79(1)4 of O. Reg. 246/22 under the FLTCA.

Rationale and Summary

O. Reg. 246/22 s. 11 (1)(b) and O. Reg. 79/10 s. 8 (1)(b), required the licensee to ensure that the process required in O. Reg. 246/22 s. 79 (1)4 and O. Reg. 79/10 s. 73 (1)5, was complied with.

A. The licensee has failed to ensure that their process to ensure food service workers and other staff assisting residents was used.

On an identified day, during lunch, dietary aide #110 did not look at the home's diet binder while plating residents' meals and dietary aide #109 looked at the binder twice. Dietary aide #109 stated that they knew the residents well.

On an identified day, during lunch, dietary aide #138 did not look at the diet binder while plating residents' meals. They stated that they looked at the binder before service to determine if there were any changes.

On an identified day, during afternoon nourishment, PSW #140 was observed providing snacks to residents. The snack cart did not have a list of residents' diets, allergies, or preferences. PSW #140 stated that the other cart had it and the nurse would communicate to them any changes in the residents' diets. No cart had a list of residents' diets.

The dietary manager explained that each servery had binders with the residents' diet textures and preference which staff were expected to use during meal service.

Failure to use the process to ensure staff are aware of the residents' diets had the risk of residents receiving food and/or fluids that were not appropriate for their needs or preferences.

B. The licensee has failure to ensure that their process to ensure food service workers and other staff assisting residents was accurate and up to date, specifically meal lists/diet binders.

Dietary aide #138 alleged that the diet binders were not updated, and staff had to go by memory when plating meals, especially with new residents.

For the period of approximately eight weeks, residents were admitted, were discharged and were internally transferred to another floor.

The diet binders showed:

- No information on residents #009, #015 and #018 after an admission or internal transfer.
- Information on residents #016 and #017 despite being transferred or discharged.
- No information on residents #010, #011 and #017 after an admission or internal transfer.
- Information on resident #001 despite being transferred or discharged.
- No information on residents #012 and #016 after an admission or internal transfer.
- Information on residents #005, #018 and #023 despite being transferred or discharged.
- Information on resident #019 was not updated to match their fluid consistency in Point Click Care (PCC). A note was attached to the cover of the diet binder but not included on resident #019's page with the rest of their information.

In Magnolia, the diet binder showed:

- No information on resident #013.

Charge nurse #143 explained that they would fill in a form with the new resident's diet texture and give it to the dietary aide who would provide it to their manager. They remembered completing a form for resident #009. The dietary manager confirmed that they are responsible for updating the dietary database when changes occur. They also explained that if a change was urgent, it would be handwritten in the diet binder.

Failure to update the information on the diet binders had the risk of residents receiving food and/or fluids that were not appropriate for their needs or preferences.

C. The licensee has failed to ensure that their process to ensure food service workers and other staff assisting residents was accurate and up to date, specifically nourishment or snack lists.

For an eight week period, residents were admitted, were discharged and were internally transferred to another floor.

The snack list did not include information on all home areas that reflected resident changes.

During the course of the inspection, the first-floor snack cart was observed in use and did not have any information on residents' diets, special needs, or preferences available.

Failure to update the information on the snack carts had the risk of residents receiving food and/or fluids that were not appropriate for their needs or preferences.

Sources: observations; diet binders, snack lists, residents' clinical records; and interviews with the Dietary Manager and other staff. [#720920]

WRITTEN NOTIFICATION – NUTRITION CARE AND HYDRATION PROGRAMS

NC#016 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 79(1)5

The licensee has failed to ensure that food was served at a temperature that was safe and palatable, specifically that actions taken when food was outside of the safe temperature ranges were documented and temperature logs were completed.

Rationale and Summary

A. Multiple food committee meeting minutes detailed complaints from residents that the hot food was often cold. The minutes from the May 19, 2022, and June 16, 2022, specifically indicated that both fish and french fries were served cold. Resident #003 confirmed food not being hot when served was an ongoing complaint from many residents and that it negatively impacted the food's palatability.

A Guide for Ontario's Food Handlers stated that food being held hot for service must be held at 60°C (140°F) or higher at all times. The home's Daily Food Temperature Log showed appropriate temperature ranges for hot food items as 60-71°C (140-160°F). For May 1, 2022, to June 22, 2022, 25 meal items were identified with a temperature recorded below the appropriate temperature for hot food items.

B. O. Reg. 246/22 s. 11 (1)(b), required the licensee to ensure that the process or policy required in O. Reg. 246/22 s. 79 (1)4, was complied with.

The Servery Production Temperature Audit policy stated that food temperatures were to be taken prior to meals being served with the outcome of having evidence that food temperatures were taken.

Temperature logs for each servery and the main kitchen were reviewed for May 1 to June 22, 2022. Several missing or illegible entries were noted for meal items, entire meals (both options), or multiple meals.

In May 2022, the temperature logs showed:

- The main kitchen had 10/31 days of missing information
- The first-floor servery had 20/31 days of missing information
- The second-floor servery had 14/31 days of missing or illegible information
- The third-floor servery had 23/31 days of missing or illegible information
- The Magnolia servery had 16/31 days of missing information

From June 1 to 22, 2022, the temperature logs showed:

- The main kitchen had 10/22 days of missing information
- The first-floor servery had 10/22 days of missing information
- The second-floor servery had 7/22 days of missing information
- The third-floor servery had 14/22 days of missing information
- The Magnolia servery had 5/22 days of missing information

Failure to document food temperatures or reheated temperatures had the risk of serving residents food that was below or above acceptable safe temperature ranges.

Sources: observations; Food Committee meeting minutes (December 16, 2021; February 17, 2022; March 17, 2022; May 19, 2022; June 16, 2022), food temperature logs, Servery Production Temperature Audit (no date), Food Safety: A Guide for Ontario's Food Handlers (September 2018); and interviews with resident #003, the Dietary Manager and other staff. [#720920]

WRITTEN NOTIFICATION – REPORTING AND COMPLAINTS

NC#017 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 23(1)(a)

The licensee has failed to ensure that every alleged, suspected, or witnessed abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated.

Rationale and Summary

Registered staff documented that resident #002 reported allegations of abuse to a staff member. There was no investigation into the allegation. The DOC no longer worked in the home. Registered staff #128 indicated that they did report the complaints to the DOC. DOC #101, who was not present during the time of the incident, confirmed there were no records of any investigation in relation to resident #002's concerns.

Sources: resident #002's clinical health records, Complaint Forms, interviews with registered staff #128 and DOC #101. [#528]

WRITTEN NOTIFICATION – REPORTING AND COMPLAINTS

NC#018 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 24(1)1

The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm, had occurred, should have immediately reported the suspicion and the information upon which it was based to the Director

Rationale and Summary

On an identified day, resident #002 reported an injured as a result of care. A Critical Incident System (CIS) report was submitted six days later. ADOC #102 confirmed that an investigation was conducted but the incident was not reported immediately.

Sources: CIS 2776-000029-21, interviews with PSW#116, RPN#128 and #132, ADOC #102, resident #002's clinical health records. [#528]

WRITTEN NOTIFICATION – REPORTING AND COMPLAINTS

NC#019 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 24(1)(2)

The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse of resident by anyone had occurred or may have occurred should have immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary

On an identified date, the resident reported allegation of abuse. Review of the Critical Incident System for reporting did not include any information related to resident #002's allegations.

Interview with DOC #101 confirmed that the allegations met the home's definition of abuse, and it was not reported to the Director.

Sources: resident #002's clinical health records, Critical Incident System, interview with DOC #101. [#528]

WRITTEN NOTIFICATION – REPORTING AND COMPLAINTS

NC#020 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with s. 101(2) of O. Reg. 79/10 under the Long-Term Care Homes Act, 2007 and s. 108(2) of O. Reg. 236/22 under the FLTCA.

The licensee has failed to ensure that a documented record was kept in the home that included,

- the type of action taken to resolve the complaint, including the date of the action, time frames for actions taken and any follow-up action that was required;
- the final resolution, if any;
- every date on which any response was provided to the complainant and a description of the response; and
- any response made in turn by the complainant.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 24622 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s.101(2) of O. Reg. 79/10. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 108(2) of O. Reg. 246/22 under the FLTCA.

Rationale and Summary

A. Food Committee meeting minutes dated December 16, 2021, February 17, 2022, March 17, 2022, and June 16, 2022, detailed complaints, issues, and concerns from the residents, including ongoing complaints of cold food. The required information regarding the type of action, resolution and responses, including a response date, was not documented on the meeting minutes or elsewhere.

The nutrition manager stated that they provided a verbal response to the food committee at the following meeting. They acknowledged that no documentation of the action, resolution or response was maintained.

Failure to keep a documented record of how complaints were resolved may have led to confusion and unresolved complaints.

Sources: food committee minutes; interviews with resident #003, Dietary Manager and other staff. [#720920]

B. (i) On an identified day, registered staff received a concern from family of resident #005, in relation to the resident not receiving care.

(ii) Additional concerns were emailed to the Registered Dietician, in relation to staff following the resident's dietary preferences. Five days later, an email response was provided to the complainant, identifying actions taken and that the information had been forwarded to the Director of Care for follow up.

Review of the resident #005's plan of care and the home's Complaint Forms from 2021, did not include the concern for resident #005, actions taken, or follow up with the complainant. DOC #101, who was not the DOC at the time, confirmed that they could not find any notes documenting the action and response for the complaints.

Sources: emails, the home's policy for Dealing with Complaints, dated March 12, 2019, interview with the DOC. [#528]

C. In 2022, resident #005 was readmitted to the home with a change in condition and new orders. Progress notes included complaints for the POA for resident #005, in relation to the new orders not being followed by staff. Review of the home's Complaint Forms did not include any documentation of the actions taken by the Director of Care (DOC) or any follow-up to the complainant. DOC #101, who was not the DOC at the of the incident, confirmed that the home did not complete a complaint form, as outlined in the home's policy Dealing with Complaints, dated March 12, 2019.

Failure to document actions taken and responses to complaints concerning the care of resident #005, placed the resident at risk of having ongoing concerns with care.

Sources: The home's policy 'Dealing with Complaints', dated March 12, 2019, interview with DOC, progress notes, 2022 complaint forms. [#528]

WRITTEN NOTIFICATION – REPORTING AND COMPLAINTS

NC#021 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s.101(3)(a)

The licensee has failed to 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 was reviewed and analyzed for trends at least quarterly.

Rationale and Summary

In June 2022, the home's documented Complaint Forms, identified 22 complaints from 2021, and ten from 2022. DOC #101 confirmed that the home policy for complaints did not include the analysis of complaints quarterly and that the home was not reviewing and analyzing the complaints forms for trends. Failure to review and analyze complaint forms, placed residents at risk of not having improvements made to the quality of care and services in the home.

Sources: The homes policy for 'Dealing with Complaints: 03-05-01, dated March 12, 2019, and interview with the DOC. [#528]

WRITTEN NOTIFICATION – REPORTING AND COMPLAINTS

NC#022 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 115(3)2(iii)

The licensee has failed to ensure that the Director was informed no later than one business day after power failure on June 16, 2022, which required the home's generator to provide full or partial power for over six hours.

Rationale and Summary

On June 16, 2022, inspectors observed lights flickering in the home and experienced computer issues.

The administrator stated that the home was experiencing power surges that were affecting the entire community. On June 17, 2022, the administrator informed inspector #528 that the home experienced a total power failure around 1800 hours lasting until approximately 2200 hours.

The maintenance manager confirmed that the home was under generator power on June 16, 2022, and stated that one heating, ventilation and air conditioning (HVAC) unit was off during the power failure as it was not on the generator.

A customer solutions representative for Alectra Utilities stated that their records show a power outage on June 16, 2022, from 1045 hours to 1330 hours, and again from 1923 hours until 0036 hours on June 17, 2022. Their computer indicated that at 0419 hours on June 17, 2022, the work was completed.

A review of the Critical Incident System (CIS) indicated that a critical incident (CI) form was not submitted for the power failure on June 16, 2022. The administrator confirmed that a CI was not submitted and stated that while the home's generator was running from approximately 1100 hours until the power was fully restored, they were receiving partial power from the utility company prior to the second outage.

Sources: observations, interviews with an Alectra Utilities representative, Administrator and other staff. [#720920]

WRITTEN NOTIFICATION – OBTAINING AND KEEPING DRUGS

NC#023 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 138(1)(a)(ii)

The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secured and locked.

Rationale and Summary
On an identified day, a medication cart was found unlocked and unattended for approximately five minutes. Registered staff was inside a resident's room with the door closed. One resident was observed standing at the cart and other residents were observed in the hallway. Registered staff #146 confirmed they had left the cart unattended, and the cart should have been locked. DOC #101 confirmed that the medication cart should be locked when unattended.

Failure to ensure that the drugs were stored safely in the medication cart, placed residents at risk.

Sources: observation, interviews with registered staff #146 and DOC #101. [#528]

WRITTEN NOTIFICATION – DIRECTIVES BY MINISTER

NC#024 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 184(3)

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every operational or policy Minister's Directive that applies to the long-term care home was complied with.

In accordance with the Minister's Directive, COVID-19 Guidance Document for Long-Term Care Homes in Ontario, the license was required to ensure that all residents are assessed at least once daily for signs and symptoms of COVID-19, including temperature checks

Rationale and Summary
The Infection Prevention and Control (IPAC) Lead stated that staff were performing COVID-19 symptom monitoring and documented it in progress notes or in assessments for cognitive residents.

Clinical records were reviewed from June 1 to June 20, 2022, for documented symptom monitoring.

- In progress notes, four home areas had one or less days of documented symptom monitoring, and two home areas had four or less days.
- In assessments, a total of 100 COVID-19 Assessment Tools were completed for 51 residents; most had one assessment in the 20-day time frame.
- In vital signs, temperatures were documented for 54 out of 162 residents.

During the time frame, no resident had more than 15 days of symptom documentation and no resident had daily temperatures recorded.

Failure to consistently document COVID-19 symptoms had the risk of staff not being aware of symptoms when they first occur.

Sources: residents' clinical records, Minister's Directive: COVID-19 response measures for long-term care homes (April 27, 2022), COVID-19 guidance document for long-term care homes in Ontario (June 11, 2022); interviews with IPAC Lead and other staff. [#720920]

WRITTEN NOTIFICATION – RECORDS

NC#025 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 274(a)

The licensee has failed to ensure a written record was maintained for resident #004.

Rationale and Summary

On an identified morning resident #004 had multiple falls. Review of the plan of care did not include a completed head injury routine following the unwitnessed falls, as required in the home's Falls Assessment Policy, dated June 1, 2022. ADOC #102 confirmed that the head injury routines were completed for the unwitnessed falls but had been misplaced.

Sources: resident #004's clinical health records, interview with ADOC #102, home's policy for Falls Assessment, dated June 1, 2022. [#528]

COMPLIANCE ORDER [CO#001] – NURSING AND PERSONAL SUPPORT SERVICES

NC#026 Compliance Order pursuant to FLTCA, 2021, s.154(1)2

Non-compliance with: O. Reg. 79/10 s. 36

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg 79/10 s. 36

The licensee shall:

a) Educate PSW staff who work on an identified home area on the safe use of the ceiling lift, according to manufacturer's instructions AP-450 Handicare Owners Manual, including:

i) the application of safety straps,
ii) using the correct sling size, and
iii) directions for staff on what to do if they do not have appropriate transferring devices.

Keep a documented record of the training, including dates and signatures of Persons who attended.

b) Complete an audit to ensure that resident #002 is being transferred using the appropriate sling size. The audit is to be done for a two-week period before the compliance due date and audits must be complete and accurate. Keep a documented record of the audit.

c) Develop and implement a written process for requesting and replacing mechanical lift slings.

Grounds

Non-compliance with: O. Reg. 79/10 s. 36

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #002.

Rationale and Summary

Resident #002 required assistance of staff for transfers using a mechanical lift. On an identified day, a progress note documented by registered staff identified that the resident did not have the appropriate size sling and that the care coordinator/ADOC was notified. ADOC #102 recalled speaking with the registered nurse and expected that the nurse obtained the correct sling from the supply in the basement. POC documentation for sling size used for one month was reviewed and included using the incorrect size.
Registered and direct care staff could not confirm when the appropriate sling size was provided.
Resident #002 and PSW #116 confirmed that on an unidentified day during the identified month, the resident had been transferred using a sling size that was incorrect. As a result, the sling was not used safely.
ADOC #102 that staff should not have been using a sling that did not fit the resident.

Failure to use the correct sling size for the ceiling lift caused resident #002 to fall.

Sources: AP-450 Handicare Owners Manual, interview with PSW#116, RPN#128 and #132, ADOC #102, resident #002's clinical health records. [528]

This order must be complied with by October 31, 2022

COMPLIANCE ORDER [CO#002] – RESIDENTS' BILL OF RIGHTS

NC#027 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021 s. 3 (1) 2

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (b) prepare, submit and implement a written plan for achieving compliance with a requirement under this Act.

Compliance Order [*FLTCA, 2021, s. 155 (1) (b)*]

The Licensee has failed to comply with s. 3 (1) 2

The licensee shall prepare, submit and implement a plan to ensure that resident #002's right to choose their lifestyle and choices is fully respected and promoted.

The plan shall include but is not limited to:

a) Collaboration with community supports, that specialize in a specific approach, to assist with the development of the plan.

b) Resident #002's involvement in the development and implementation of the plan.

c) Safe storage of items.

Please submit the written plan for achieving compliance for inspection #2022_1267_0002 to Cynthia Di Tomasso, LTC Homes Inspector, MLTC, by email to HamilonSAO.moh@ontario.ca by September 14, 2022.

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

Grounds

Non-compliance with: FLTCA, 2021 *[s. 3 (1) 2]*

The licensee has failed to ensure that resident #002's right to have their lifestyle and choices, were fully respected and promoted.

Rationale and Summary

The licensee has failed to ensure that resident #002's right to have their lifestyle and choices, were fully respected and promoted.

The plan of care for resident #002 identified that the resident had multiple comorbidities and was able to make care decisions.

After being admitted to the home, the resident expressed wishes in relation to a certain lifestyle choice, which was not supported by the home and changes were made to their plan of care without involvement of the resident.

Although the resident had continued to express their lifestyle choices, the home did not consider any other approaches to try and support the resident's choice and therefore failed to fully respect and protect the resident's right.

Sources: resident #002's clinical health records, interviews with the physician, Administrator #100, DOC #101, ADOC #102 and #127, registered staff #124 and #128, PSW #119, SW #125, interview with the Canadian Mental Health Association Community Support Counsellor #149. [#528]

This order must be complied with by October 31, 2022

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

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7
Telephone: 1-800-461-7137
HamiltonSAO.moh@ontario.ca

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. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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:

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

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7
Telephone: 1-800-461-7137
HamiltonSAO.moh@ontario.ca

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
email: 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.