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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: June 27, 2023	
Inspection Number: 2023-1267-0005	
Inspection Type: Critical Incident System	
Licensee: Heritage Green Nursing Home	
Long Term Care Home and City: Heritage Green Nursing Home, Stoney Creek	
Lead Inspector Carla Meyer (740860)	**Inspector Digital Signature**
Additional Inspector(s) Angela Finlay (705243)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 29th-31st, and June 1st-2nd, 2023

The following intake(s) were inspected:

- Intake: #00088683 related to unlawful conduct.

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

Infection Prevention and Control
Medication Management
Staffing, Training and Care Standards
Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: Security of drug supply

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

Non-compliance with: O. Reg. 246/22, s. 139 2. i.

The licensee failed to ensure that steps were taken to restrict the access of drug supplies only to persons who may dispense, prescribe, or administer drugs in the home.

Specifically, a staff who was not a member of a regulated health professions and did not have authorization to administer medications, had access to the home's drug supplies including controlled substances.

Rationale and Summary

An agency staff worked as a Registered Practical Nurse (RPN) at the home for a total of five shifts in November 2022. In May of 2022, the home was notified by the agency that the staff member was not registered with the College of Nurses of Ontario (CNO) and had forged documentation, therefore did not have authorization to access drug supplies in the home.

The security of drug supplies in the home was compromised. This placed the safety and well-being of residents at risk for adverse drug events as the staff member did not have the authority under the Regulated Health Professions Act, 1991; was not acting within a scope of practice of a health professional; nor had the certifiable skills or knowledge to administer medications.

Sources: Interview with the DOC; staff roster, eMARs, and Narcotic Drug Book and count sheets, and CNO's list of unregistered practitioners.

[740860]

WRITTEN NOTIFICATION: Administration of drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (3)

The licensee failed to ensure that a staff member who was not a RPN, did not administer drugs to residents in the home.

Rationale and Summary

An agency staff, who was determined to be an unregistered practitioner worked in the home as a RPN for a total of five shifts. There was a total of 17 residents within this time-period that had medications

administered to by this staff member.

Residents were placed at risk of harm when they received prescribed medications from the staff member who did not have certifiable knowledge, skills and experience to administer medications by the CNO.

Sources: Staff daily roster for November 2022, CNO's list of unregistered practitioners, eMAR report; and interview with the DOC.

[740860]

WRITTEN NOTIFICATION: Exemptions, training

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 262 (2)

The licensee failed to ensure that a staff member was provided with information about items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 82 (2) of the Act before providing their services.

Rationale and Summary

In accordance with the FLTCA, 2021, s. 82 (2), paragraphs 1, 3, 4, 5, 7, 8 and 9, states that every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.

Furthermore, subsection 82 (1) of the Act states that Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section.

An agency staff member who was later determined as an unregistered practitioner, worked for the home on five specified dates in November of 2022. The staff member did not receive the four-hour in-

class orientation and the orientation booklet required prior to commencement of work at the home, nor were they added to Surge Learning.

Failing to ensure that the staff member received the information as listed above before providing their services placed the residents at risk for receiving improper care.

Sources: Interview with the DOC, and Clinical Educator; staff daily roster for November 2022; the home's policy titled, "Education: Orientation," dated August 24, 2021, a document titled, "Nursing Agencies/Contracts – Guidelines/Procedures," and the home's Surge Learning mandatory list of education.

[740860]

COMPLIANCE ORDER CO #001 Certification of nurses

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 51

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with [FLTCA, 2021, s. 155 (1) (b)]:

The plan must include but is not limited to:

The licensee shall prepare, submit and implement a plan to ensure that every member of the registered nursing staff, including registered staff working at the long-term care home pursuant to a contract between the licensee and an employment agency or other third party, has the appropriate current certificate of registration with the College of Nurses of Ontario prior to working in capacity of a registered nurse, registered practical nurse, or registered nurse in the extended class.

The plan must include but is not limited to:

1. Consideration of incorporating into the home's policy, a plan to validate and ensure that every member of the staff who performs duties in the capacity of registered nurse, registered practical nurse or registered nurse in the extended class has the appropriate current certificate of registration with the College of Nurses of Ontario (CNO), by utilizing the CNO's Find a Nurse tool and list of unregulated practitioners.

2. Consideration of validating all CNO certificate of registration for all members of the home's registered

nursing staff, including agency staff and include a copy of this record in the staff employee file.

3. Ensuring that no person who is not a current and certified member of the CNO works in the capacity of a registered nursing staff in the home.

Please submit the written plan for achieving compliance for inspection #2023-1267-0005 to Carla Meyer (740860), LTC Homes Inspector, MLTC, by email to hamiltondistrict.mltc@ontario.ca **July 11, 2023.**

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

Grounds

Non-compliance with: O.Reg. 246/22, s.51

The licensee failed to ensure that a member of the staff who performed duties in the capacity of a RPN, had the appropriate current certificate of registration with the CNO.

Rationale and Summary

In May 2023, the Ministry of Long-term Care received a Critical Incident (CI) report about an unlawful conduct that resulted in risk of harm to resident related to a staff member who had worked in the home for a total of five shifts.

The CI report identified that a staff member was a RPN from an agency used by the home. It came to the home's attention through discussion with the agency supervisor in May 2023, that the staff member had forged their documents, was not registered with the CNO, and was listed under the CNO's unregulated practitioners.

The home did not conduct their own search of the staff member's credentials using the CNO tools of Find a Nurse and Unregistered Practitioners prior to becoming aware of their registration status. The home did not have a process in place to ensure the validity of the staff at the time of the incident.

By failing to ensure that the staff member had the appropriate credentials to certify that they possess the knowledge, skills and experience of a RPN, the residents were placed at risk of harm or actual harm.

Sources: Interview with the DOC; CI:2776-000031-23, Agency contracts, Agency contract guidelines, staff schedule, staff member's records; CNO's Find a Nurse tool, and CNO's list of Unregistered Practitioners.

[740860]

This order must be complied with by August 23, 2023

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;
(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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) 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:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) 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:

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
e-mail: 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.