Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Original Public Report

Report Issue Date: September 06, 2024
Inspection Number: 2024-1267-0003
Inspection Type: Complaint Critical Incident
Licensee: Heritage Green Nursing Home
Long Term Care Home and City: Heritage Green Nursing Home, Stoney Creek

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 20-23, 26-28, 2024

The following intake(s) were inspected:

- Intake #00113107/ CI #2776-000022-24 and Complaint Intake #00120158 related to Resident Care and Support Services.
- Intake #00119402/ CI #2776-000033-24 related to Infection Prevention and Control.
- Intake #00121451/ CI #2776-000038-24 related to Falls Prevention and Management.

The following intakes were completed in this inspection:

- Intake #00113657/ CI #2776-000023-24; Intake #00120355/ CI #2776-000036-24 related to Falls Prevention and Management.

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

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Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

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: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident’s care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident’s care needs changed or care set out in the plan was no longer necessary.

Rationale and Summary
On two consecutive days, Inspector observed a resident wearing a hospital gown.

Staff explained that the resident had injuries on their neck and back, so they implemented the use of hospital gown to help with the healing process. Staff

acknowledged that the resident 's plan of care should have been reviewed and revised to include this intervention, but it was not.

On the second day, the resident 's plan of care was reviewed and revised with the above intervention.

Sources: Resident's observation; Resident's clinical records, Interview with staff.

Date Remedy Implemented: August 22, 2024.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident had occurred or might occur, immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary
Resident's Substitute Decision Maker (SDM) reported to the Long-Term Care (LTC) home staff an allegation of neglect causing harm to the resident by staff, however the allegation was not immediately reported to the Director.

Assistant Director of Care (ADOC) acknowledged that the allegation of neglect should have been immediately reported to the Director.

Sources: Resident's clinical records; SDM complaint; Interview with ADOC.

WRITTEN NOTIFICATION: General Requirements - documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (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.

The licensee has failed to ensure that actions taken with respect to a resident under a Pain Assessment Program, including pain assessment and reassessment and the resident's responses to interventions were documented.

Rationale and Summary
Progress note documentation identified that a resident had their third fall early in the morning on a specific day. Later, on the same day, the resident was in pain, when a staff member performed a range of motion for them.

Point Click Care (PCC) Assessment tab, Risk Management Report (RMR) and progress notes did not indicate a completion of documentation by using the Pain Assessment Tool for Cognitively Impaired or Non-Communicative Residents for that day.

The Pain Assessment Policy directed staff to use the Pain Assessment Tool for Cognitively Impaired or Non-Communicative Residents, when a resident complained of pain, which was confirmed by the Clinical Educator.

Sources: The PCC Assessment tab; Risk Management Report; Progress notes; Interview with the Clinical Educator.

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident after they had a fall.

Rationale and Summary
Progress notes documentation indicated that a resident had two unwitnessed falls in one day. The resident was found on a floor in their home area.

A staff member confirmed that they helped the resident after the first and the second falls without using the required equipment but assisting them physically with a help from another staff member.

The Fall Prevention Policy directed staff to use the required equipment to assist resident after they had fallen, which was confirmed by the Clinical Educator.

Sources: Progress notes, the Falls Prevention Policy; interview with RPN #105 and the Clinical Educator.

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that Falls Prevention Policy, which included strategies to monitor a resident, was followed.
In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee of a long-term care home was required to have, institute or otherwise put in place a Falls Prevention Policy to ensure that the policy was complied with.

Rationale and Summary
The resident had a number of falls on the same day. The staff member who assessed the resident indicated that the Post Fall Huddle was not completed after the resident had a fall.

The Assessment tab in the Point Click Care (PCC) and progress notes for the resident did not identify that the staff completed the Morse Fall Scale assessment and the Post Fall Huddle form after the resident's first fall.

The Fall Prevention Policy directed staff to undertake the Morse Fall Scale

assessment to assess the risk for the resident for further falls and to complete the mandatory Post Fall Huddle after each fall, which was confirmed by the Clinical Educator.

Sources: The Fall Prevention Policy, the PCC Assessment tab, progress notes; interview with staff.

COMPLIANCE ORDER CO #001 Plan of care

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee must ensure that the care set out in the plan of care is provided to the resident as specified in their plan for toileting.

Specifically, the licensee must:
-Ensure that the identified staff member follows the resident's plan of care for toileting by completing daily audits during a two-week period, and that a documented action plan is in place if any audit findings identify deficiencies.
-Keep a copy of the audits and ensure they are readily available for Inspector review.

Grounds
The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in their plan for toileting.

Rationale and Summary
The resident's plan of care indicated that they required two person total assistance for the entire toileting process.

A staff member independently toileted the resident and the resident fell resulting in transfer to hospital with injuries.

The Long-Term Care (LTC) home's investigation notes and interview with the Assistant Director of Care (ADOC) confirmed that the staff member did not follow the resident's plan of care.

Failure to follow the plan of care for toileting caused harm to the resident.

Sources: Resident's clinical record; Investigation notes; Interview with staff.

This order must be complied with by October 11, 2024

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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.