Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Feb 24, 27, 28, 29, Mar 1, 2, 6, 7, 8, 9, 12, 15, Apr 19, 23, 24, May 1, 8, 30, 2012	2012_065169_0003	Complaint

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

YVONNE WALTON (169), MICHELLE WARRENER (107), RICHARD HAYDEN (127)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with The Administrator, Assistant Administrator, Director of Care, Registered Dietitian, Registered staff, RAI-Coordinator, front line nursing and dietary staff, Food Service Manager, Assistant Food Services Manager, Environmental Manager, residents and family members.

During the course of the inspection, the inspector(s) Reviewed clinical health records, observed several meal services, reviewed relevant policies and procedures, and observed food production systems related to complaints H-001894-11, H-002427-11 and H-000566-12. Environmental inspection occurred in laundry, resident rooms, dining rooms and common areas. Care toward residents was observed being provided by staff.

PLEASE NOTE: Two non-compliances were found under the Long Term Care Homes Act, related to the Licensee's failure to comply with ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, and ensuring that the resident is 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 change or care set out in the plan is no longer necessary.
The following Non-compliances were issued [LTCHA, s. 6(7) and 6(10)(b)] in inspection #2012_066107_0006/H-000571-12, conducted on March 7, 2012 and are contained in the report of that inspection.
This report refers to the following complaints: H-002313-11, H-02075-11, H-02085-11, H-01792-11, H-02427-11, H-001894-11.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Continence Care and Bowel Management

Critical Incident Response

Dining Observation

Medication

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 15. Accommodation services

Specifically failed to comply with the following subsections:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the home's equipment was kept clean and sanitary. Several wheelchairs were observed soiled throughout the home. On March 1, 2012, the inspector spoke with the director of care, who advised the wheelchairs have not been cleaned since October 2011.
2. On February 28, 2012, the inspector toured the home and observed the following housekeeping issues:
a. Food splatter and food residue on the walls of the 3rd floor secure unit dining room servery.
b. Dining room chairs in all dining rooms presented with food spillage and food residue on seats, backs, legs and arms.
c. Lounge chairs for residents were soiled with unknown substances.
d. An identified resident's air bed mattress was soiled and had a malodorous urine smell.
e. An identified resident's falls mat and the carpet next to the bed were soiled.
f. An identified resident's toilet, sink and washroom floor were soiled and in need of cleaning.
3. On February 28 and 29, 2012, the inspector toured the home and observed the following maintenance issues:
a. More than 30 patched wall areas had not been repainted in the 3rd floor secure unit dining room, lounge 383, hallway and nursing station.
b. Fourteen resident rooms presented with wall damage, peeling paint, wall repairs that had not been repainted, detached baseboards and/or new closet doors and door frames that had not been painted.
c. The door frames for the majority of resident rooms on the 3rd floor presented with chipped/worn paint and the metal frames were exposed.
d. A washroom vanity was warped due to water damage.
e. Light bulbs were not functioning in several rooms.

On March 1, 2012, the inspector met with the maintenance supervisor who identified the part-time painter was scheduled to work Monday to Wednesday each week but has been off frequently during the last four to six months. There was no plan to replace the painter when off.

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 that ensures the home, furnishings and equipment are kept clean and sanitary and maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following subsections:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces;
(c) removal and safe disposal of dry and wet garbage; and
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the housekeeping program is developed and implemented to ensure cleaning of the resident wheelchairs.
On March 1, 2012, the inspector spoke with the staff, who advised that wheelchair cleaning is not completed by nursing staff but only "refresh" them as needed. Staff stated the part-time employee who was responsible for deep cleaning the wheelchairs and walkers left for a full-time job and this equipment has not been cleaned since October 2011.
2. On February 28, 2012, the inspector toured the home and observed 13 resident's wheelchairs and/or walkers were soiled with dust, dirt, food spillage and/or food residue. On March 2, 2012, the inspector met with staff regarding wheelchair cleaning. The policy provided was dated April 2011. It stated that wheel chairs and walkers are steam cleaned and/or power washed quarterly in a systematic way during the months of January, April, July and October. The procedure continues until all the wheel chairs and walkers have been steam cleaned or washed. Personal Support Workers are supposed to wipe spills from wheel chairs and walkers as soon as they occur to prevent the substances from drying on.

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 that ensures housekeeping services are part of the organized program of housekeeping under clause 15 (1) (a) of the Act, and ensures the procedures are developed and implemented for cleaning and disinfection of resident care equipment, such as whirlpools, tubs, shower chairs, and lift chairs and supplies and devices, including personal assistance devices, assistive aids, and positioning aids and contact surfaces, using hospital grade disinfectant and in accordance with manufacturer's specifications, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following subsections:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items;
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents;
(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and
(d) industrial washers and dryers are used for the washing and drying of all laundry. O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure linen is kept clean and sanitary and are maintained in a good state of repair. On February 29, 2012, the inspector observed that 30% of resident clothing protectors in three dining rooms were in disrepair with worn and frayed edges. On March 1, 2012, the inspector met with the housekeeping/laundry supervisor. A new supplier that provides better quality products has been contracted and the frayed clothing protectors will be replaced.

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 that ensure linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. an identified resident was not transferred in a safe way resulting in an injury. The identified resident was transferred from bed to chair using a lift that was not identified in the plan of care. The resident sustained an injury as a result of the transfer. The clinical progress notes, the critical incident report and the Director of Care confirmed staff used an unsafe transfer device.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
3. A missing or unaccounted for controlled substance.
4. An injury in respect of which a person is taken to hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The home did not notify the Director within one business day after a resident went to the hospital for assessment and treatment. The licensee became aware the resident had an injury and the critical incident was not reported for 3 days.

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 that ensures the Director is informed of incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4). An injury in respect of which a person is taken to hospital, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following subsections:

s. 229. (2) The licensee shall ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program;
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly;
(c) that the local medical officer of health is invited to the meetings;
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the infection prevention and control program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. On March 2, 2012, the inspector reviewed the Heritage Green Nursing Home's infection control manual. All sections of this manual were last updated in either February 2008 or November 2008. There was no indication that any section had been evaluated and updated at least annually in 2010 or 2011. The inspector met with the home's staff regarding the infection control manual. Staff confirmed the infection control manual dated November 2008 was the most current version for the home and has not been updated since then.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that an identified resident was treated with courtesy and respect and in a way that fully recognizes the resident's individuality and dignity.
The identified resident was observed walking in the hall with the assistance of two staff members, one on each side of the resident. Observation revealed the identified resident was wearing a white brief with the buttocks exposed completely. The two staff were restorative aides and were assisting the resident in the walking program.
The resident was not provided with a dignified approach to care.

Issued on this 30th day of May, 2012

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