

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

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

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

**Division des opérations relatives aux
soins de longue durée
Inspection de soins de longue durée**

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 1, 2020	2020_520622_0019	002623-20, 007132-20, 017873-20, 018119-20, 019622-20, 020928-20	Critical Incident System

Licensee/Titulaire de permis

Heartwood Operating Inc.
5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

Long-Term Care Home/Foyer de soins de longue durée

Heartwood
201 - 11th Street East Cornwall ON K6H 2Y6

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

HEATH HEFFERNAN (622), EMILY PRIOR (732)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 26, 27, 28, 29, 30, 2020 and November 2, 3, 4, 5, 6, 2020.

The following intakes were completed in this Critical Incident System Inspection:

Log #017873-20 and Log #002623-20, were related to alleged abuse.

Log #020928-20, Log #007132-20, and Log #019622-20, were related to falls.

Log #018119-20, was related to a medication incident/adverse drug reaction.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), the Assistant Director of Care (ADOC), the Office Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and the residents.

During the course of the inspection, the inspectors observed resident and staff interactions, resident care and services, reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Hospitalization and Change in Condition

Medication

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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

2 WN(s)

2 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

- 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,
- (a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
 - (b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
 - (c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident was reassessed for fall risk; the plan of care was revised when the resident's care needs changed.

A resident fell, sustained an injury, and was transferred to hospital as a result.

Inspector #622 reviewed the latest Fall Risk Screen which stated that the resident was assessed as a high risk for falls, and was to be considered a falling star.

The current care plan stated that the resident was a low risk for falls, and there was no mention of a falling star logo. The kardex did not contain the level of risk for falls and the resident's name plaque did not contain a falling star logo next to their door.

SOURCE: Resident care plan, kardex, fall risk screens, observation of resident care and services, interviews with Director of Care and other staff. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to 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, the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24.
Reporting certain matters to Director****Specifically failed to comply with the following:**

s. 24. (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:

- 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 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. 2007, c. 8, s. 24 (1), 195 (2).**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

Findings/Faits saillants :

1. The licensee failed to ensure that a person who has reasonable grounds to suspect that the alleged abuse of a resident by a Registered Practical Nurse (RPN) that resulted in harm or risk of harm was reported to the director.

Critical Incident System report (CIS), stated that a resident was observed in their room upset and crying. The resident reported to the Office Manager that a RPN had made rude comments to them, which caused them to be upset and to cry. The Ministry of Long-Term Care after hours pager was not notified. The CIS report was submitted to the Ministry of Long-Term Care four days later.

Office Manager stated that they had not reported the resident's complaints related to the RPN to the Ministry of Long-Term Care. The Office Manager said that they submitted the allegation of staff to resident abuse to the Executive Director (ED), who reported the allegation to the Ministry of Long-Term Care when the incident was reported to them, four days late.

SOURCE: Review of the Critical Incident Report, interview of the Office Manager and the Executive Director. [s. 24. (1)]

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 to ensure that when 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: 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, to be implemented voluntarily.

Issued on this 11th day of December, 2020

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

Original report signed by the inspector.