Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 19, 2021	2021_809733_0004	022400-20, 023379-20, 023807-20, 025074-20, 025256-20, 025362-20, 000119-21, 000383-21	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

MARK MCGILL (733), HEATH HEFFERNAN (622)

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): March 8, 9, 10, 11, 12, 16, 17, 18, 19, April 12, 13, 14, 15, 2021

log 000383-21 (CIS: 2088-000003-21), log 025362-20 (CIS: 2088-000001-21) and log 023807-20 (CIS: 2088-000037-20) were related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.
log 000119-21 (CIS: 2088-000001-21) was related to improper/Incompetent treatment of a resident that resulted in harm or risk to a resident.
log 023379-20 (CIS: 2088-000034-20) was related to an adverse reaction that altered the resident's health status.
log 025256-20 (CIS: 2088-000040-20) and log 022400-20 (CIS: 2088-000030-20) were related to alleged neglect.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPN), Nurses Aide, IPAC Manager and Personal Support Workers (PSWs).

Also during the inspection, the inspector reviewed the related Critical Incident System reports (CIS), the licensee's investigation documentation, health records, the licensee's policies and procedures – Safe Resident Handling – Operation of Mechanical Lifting/Transferring and Repositioning Devices CARE6-O10.06-LTC, CARE6-O10.07-LTC, Falls Prevention and Injury Reduction Program – CARE5-P10, Mandatory Reporting of Resident Abuse or Neglect – ADMIN-O10.01 and made observations of resident care and services.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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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	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident’s plan of care.

A Critical Incident System report stated that the long-term care home received a complaint that a resident's Substitute Decision Maker (SDM) had not been informed of an incident involving the resident being transferred improperly by one staff and was lowered to the floor.

A Registered Nurse (RN) stated that they became aware that a PSW transferred a resident improperly resulting in the resident being lowered to the floor. The RN stated that they had not reported the incident to the resident's SDM.

Sources: review of CIS Report, health records and interview of an RN and other staff. [s. 6. (5)]

2. The licensee has failed to ensure that the care set out in the plan of care related to transfers for a resident was provided to the resident as specified in the plan.

A Critical Incident System report (CIS) stated that a Personal Support Worker (PSW) had transferred a resident independently and the resident was lowered to the floor.

The Director of Care (DOC) stated that while investigating the original incident, they determined that a second PSW had also transferred the resident independently.

The resident's plan of care stated that they required two persons, side by side transfer for all transfers.

Sources: review of CIS Report, health records and interview with the DOC. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan., 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 has failed to ensure that the person who had reasonable grounds to suspect neglect of a resident by a Registered Nurse (RN), immediately reported the suspicion and the information upon which it was based to the Director.

A Critical Incident System report stated that a written complaint was received by the licensee related to the care of a resident by an RN.

The Executive Director stated that they felt the written complaint had tones of neglect related to a resident, and reported the complaint to the Ministry of Long-Term Care by Critical Incident System report (CIS) two days late.

Sources: review of the Critical Incident System report and interview with the Executive Director. [s. 24. (1)]

2. The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper care of a resident had occurred and placed them at risk of harm, was immediately reported the to the Director.

Review of the Ministry of Long-Term Care, after-hours telephone report and a Critical Incident System report (CIS) indicated that a complaint had been received by the licensee stating that a resident was lowered to the floor when an improper transfer using one person, had been completed. During the licensee's investigation, the date of the incident was determined to be on a date in December 2020. The licensee had not reported the incident of improper care to a resident by a PSW until after the complaint was received eight days later.

Sources: review of the Ministry of Long-Term Care, after-hours telephone report and a Critical Incident System report (CIS) [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 neglect is immediately reported to the Director, to be implemented voluntarily.

Issued on this 11th day of June, 2021

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

Original report signed by the inspector.