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

Ottawa Service Area Office
347 Preston Street, Suite 420
Ottawa ON K1S 3J4
Telephone: 1-877-779-5559
OttawaSAO.moh@ontario.ca

Original Public Report

Report Issue Date July 28, 2022
Inspection Number 2022_1046_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Heartwood Operating Inc.

Long-Term Care Home and City
Heartwood, Cornwall, ON.

Michelle Edwards
2022.08.12 16:34:34 -04'00'

Lead Inspector
Michelle Edwards (655)

Inspector Digital Signature

Additional Inspector(s)
Sarah Stephens (740823) was present for the duration of the on-site inspection.

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 5, 6, 9, 11, 12, 2022 – off site. May 24, 25, 26, 27, 30, 31, 2022, and, June 1, and 2, 2022 – onsite.

The following intake(s) were inspected:
- Log #019616-21 and 019529-21 – related to an injury of unknown cause, and alleged staff-resident abuse,
- Log #00870-22 – related to alleged staff-resident abuse,
- Log #010244-22 – related to alleged staff-resident neglect,
- Log #008672-22 – related to alleged unlawful conduct by a staff member,
- Log #000776-22 – related to an incident of resident-resident physical abuse; and,
- Log #008280-22 – related to a fall.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Staffing, Training and Care Standards

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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#01 remedied pursuant to FLTCA, 2021, s. 154(2)

Non-compliance with: O. Reg. 246/22 s. 102 (2) b

The licensee failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with.

In accordance with additional requirement 9.1 under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022), additional precautions must, at a minimum, include evidence-based practices related to potential contact transmission and required precautions. In the IPAC Standard, a Public Health Ontario (PHO) document titled Routine Practices and Additional Precautions (PIDAC, 2012), is identified for further guidance related to evidence-based practices.

In PHO's Routine Practices and Additional Precautions (PIDAC, 2012), it is stated that where a resident requires additional precautions, a sign that lists the required precautions should be posted at the entrance of the resident's room or bed space.

During the inspection, the health care record belonging to a resident was reviewed, including progress notes. In a specific entry, it was indicated that the resident had tested positive for an infectious organism which required contact precautions to be in place, and that an isolation caddy had been placed on the resident's room door. In addition, a note was found in the "RN Communication Book" which stated the same.

However, on the same day, it was observed that there was no signage posted on the resident's door to indicate what the required precautions were. At the time of the observation, staff (including a PSW and RPN) did not know if additional precautions were to be in place for this resident.

During an interview, an RPN confirmed that at the time of the above-noted observation, there had been no signage related to the additional precautions posted at the entrance of the resident's room. The same RPN indicated that they had since posted the appropriate signage.

Inspector # 655 conducted a subsequent observation, at which time, it was observed that the required signage outlining the required contact precautions was in place at the entrance of the resident's room.

Date Remedy Implemented: May 27, 2022 [655]

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WRITTEN NOTIFICATION – INFECTION PREVENTION AND CONTROL PROGRAM

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102 (2) b

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with.

In accordance with additional requirement 10.4 under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022), the Licensee shall ensure that the hand hygiene program includes support for residents to perform hand hygiene prior to receiving meals.

Rationale and Summary

During the inspection, Inspector #655 observed approximately eight residents enter a dining room for their lunch-time meal. The observations were conducted between the hours of 1153 and 1220. Five of the residents observed were accompanied by a staff member. During the observation period, Inspector #655 observed one resident to be supported in performing hand hygiene. No other residents were observed to perform hand hygiene prior to receiving their meal.

At the same time, Inspector #655 observed a sign posted next to the entrance of the dining room, which read as follows:

"*Hand hygiene must be completed for all residents entering and exiting the dining room at each meal. Encourage resident to use hand sanitizer on their own when possible. Staff are to use Certainty wipes on residents if they are unable to assist with their own hand hygiene".*

During an interview, it was confirmed that residents were expected to be supported with hand hygiene at the point of entry to the dining room, prior to a meal, and on exiting the dining room. At the same time, it was indicated that where a resident is unable to rub the alcohol-based hand rub onto their own hands; staff are required to use specified hand wipes to clean the resident's hands.

The licensee failed to ensure that the IPAC standard was complied with when residents were not supported to perform hand hygiene prior to a meal, posing a risk for infection to residents.

Sources: observations of resident's entering the dining room; a review of signage posted outside of the second- floor dining room; and interviews with staff including a PSW and IPAC Lead.

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WRITTEN NOTIFICATION – PLAN OF CARE

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6 (1) c

The licensee has failed to ensure that there was a written plan of care for a resident which set out clear directions to staff and others who provide direct care to the resident, with regards to the resident's mobility needs.

Rationale and Summary

Over the course of the inspection, a resident was observed by Inspector #655 to be using a specific mobility device.

Inspector #655 reviewed the health care records belonging to the resident, who had a history of falls, one of which resulted in injury.

The above-noted mobility device which was observed to be in use by the resident at the time of the inspection was not identified in the resident's care plan. The care plan further directed staff to remind the resident to use a different type of mobility aid.

In a progress note, however, it was indicated that the resident was to use the mobility device that was observed by the Inspector to be in use at the time of the inspection.

During an interview, a nurse indicated that they were unsure whether the resident still used the mobility aid identified in the care plan. At the same time, they confirmed that the resident had been using the specific mobility device that the Inspector observed to be in use by the resident more often, though the resident's care plan did not include directions pertaining to its use.

The licensee failed to ensure that the written plan of care for the resident set out clear directions to staff with regards to the resident's mobility needs; and specifically, related to the use of a mobility device. As a result of unclear direction, there is a risk for resident injury should a staff member implement the incorrect mobility device.

Sources: Resident health care records, including: progress notes, care plan, and various post-fall assessments; interviews with the resident and staff, including a PSW and nurse.
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WRITTEN NOTIFICATION – PLAN OF CARE

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6 (7)

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

Rationale and Summary

Over the course of the inspection, it was determined that a particular resident's plan of care included the provision of one-to-one supervision.

Inspector #655 reviewed the progress notes in the resident's health care record. In the progress notes, the resident was described as exhibiting worsened symptoms when the one-to-one supervision was not in place. According to the progress notes, the resident did not have someone assigned to them for one-to-one supervision on specified date.

During an interview, a nurse also indicated that the resident did not have one-to-one supervision in place on the date specified in the progress notes.

As such, the licensee failed to ensure that the care set out in the plan of care with regards to the need for one-to-one supervision for a resident was provided to the resident as specified in the plan. Without supervision, the resident and co-residents were at risk for potential harm.

Sources: observations of the resident, review of the resident's health care records, including progress notes and care plan; interviews with staff, including: a PSW, members of the management team and other staff.

[655]

WRITTEN NOTIFICATION – RECREATIONAL CANNABIS

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22*, s.* 142. (1)

The licensee has failed to ensure that the written policy and procedures to govern, with respect to residents, the acquisition, consumption, and possession of recreational cannabis were complied with.

In accordance with O. Reg. 246/22, s. 11 (1) b, the licensee is required to have a policy to govern, with respect to residents, the acquisition, consumption, and possession of recreational cannabis, and to ensure that the policy is complied with.

Specifically, staff did not comply with the licensee's policy titled "LTC – Recreational Consumption of Cannabis". In the policy, procedural requirements related to the use of recreational cannabis by residents in the long-term care home are outlined. The tools to be utilized by staff, including the "LTC - Cannabis Assessment Tool", and the "LTC – Smoking/Vaping Contract Tool", were also identified in the policy.

Rationale and Summary

The licensee's policy was not complied with in the following ways:

1. **The procedures related to the use and implementation of the Smoking/Vaping contract were not followed.**

In accordance with the licensee's policy titled "LTC – Recreational Consumption of Cannabis" the Smoking/Vaping contract must be signed by both the resident and the Executive Director of the long-term care home at which the resident resides: (i) following the resident being approved under the Cannabis Assessment; and (ii) on an annual basis thereafter.

On review of the "LTC – Smoking/Vaping Contract Tool" referred to in the above-noted policy, it was found to include the following statements:

I understand that I cannot hold or possess my cigarettes/e-cigarette vaporizer and matches/lighter at any time, except when I am outside smoking/vaping. This includes my matches/lighter for the purpose of smoking/vaping cannabis.

The consequences of not adhering to the contract are also outlined in the tool.

During the inspection, Inspector #655 reviewed the health care records belonging to a resident who was a consumer of recreational cannabis.

On review of the resident's health care records, Inspector #655 was able to locate only one completed contract which had been signed by the resident and Executive Director, as required by the licensee's policy. A recent contract could not be found.

In progress notes entered by registered nursing staff, it was indicated that the resident failed to return their lighter to staff on multiple occasions and that they kept their lighter in their own room, in their own locked drawer.

During an interview, a nurse indicated that there are other residents who reside at the long-tern care home and who smoke or consume cannabis and do not return their lighters to staff after use.

2. **The resident assessment processes related to the use of recreational cannabis were not complied with.**

According to the above-noted policy, a comprehensive cannabis assessment will be completed by an interdisciplinary team for a resident who is identified to be a recreational consumer of cannabis. The policy states that for those residents, an assessment must be completed at the time of the resident's admission and from time to time, where a need to do so is identified by the interdisciplinary team. In the policy, the "LTC-Cannabis Assessment Tool" was the identified assessment tool. The tool was observed to include a prompt at the end of assessment to recommend a discussion take place between the resident and physician or nurse about the risks of recreational cannabis use. According to the policy, the purpose of the assessment is to ensure that the resident can consume cannabis in a manner that does not expose themselves, or others, to risk.

During the inspection, Inspector #655 reviewed the health care records belonging to a resident who was a consumer of recreational cannabis and found that the "LTC-Cannabis Assessment Tool" had not been used, at any time, for the resident. A smoking assessment tool, however, had been utilized on a quarterly basis.

During an interview, a nurse indicated that they were not familiar with an assessment process pertaining specifically to the use or consumption of recreational cannabis. The nurse indicated that on the home area where they currently work, there is a resident who is a known consumer of recreational cannabis; and that, for that resident, they do the smoking assessment on a quarterly basis, but not specifically related to the use of cannabis.

During an interview, another nurse indicated to Inspector #655 that they were aware only of a smoking policy which they suspected recreational cannabis would fall under. They further indicated that they were aware of a smoking assessment tool and that they "assumed" the same tool would be used for residents who consumed recreational cannabis.

During the inspection, Inspector #655 reviewed the "smoking assessment" completed for a resident.The assessment tool did not include any terminology related to the use of cannabis; nor did it include a prompt to recommend that the resident discuss the risks associated with recreational cannabis use.

3. **There was no record of a discussion between a physician or nurse and a resident who was a consumer of recreational cannabis (or their SDM) related to the risk of recreational consumption specific to the resident's medical condition.**

According to the licensee's policy titled ""LTC – Recreational Consumption of Cannabis", a physician or nurse is to discuss the risks of recreational consumption of cannabis specific to the resident's medical condition with the resident or their SDM following a resident's cannabis assessment. The details of any discussion between a resident and the home's staff regarding recreational consumption of cannabis is to be documented in the resident's health care record, according to the policy. During the inspection, Inspector #655 reviewed the health care record belonging to a resident who was a consumer of recreational cannabis, and could not find a record of a documented discussion between a physician or nurse and the resident (or SMD) related to the risks of recreational consumption of cannabis specific to the resident's medical condition until a specific date - the same day the resident experienced a adverse event, which was suspected at the time, to be related to the use of cannabis. The same resident was described in the progress notes as experiencing deteriorating health over a period of time. In one note, the resident was also described as consuming cannabis in a different manner. During an interview, a nurse indicated to Inspector #655 that this resident's physician was made aware of the resident's cannabis use; but that there was otherwise no process in place to ensure that the physician or nurse discusses the risks of recreational cannabis use with the resident or SDM in the context of the individuals own medical conditions. During an interview, a member of the home's management team indicated to Inspector #655 that they have not been at the bed side to see whether a physician or nurse has a discussion related to the risk of recreational cannabis use with a resident or SDM in the context of the resident's own medical conditions. The licensee's policy titled "LTC – Recreational Consumption of Cannabis" was not complied with. As a result, there was a risk of harm to the resident who consumed recreational cannabis, and other residents related to the potential for unsafe use of recreational cannabis by the resident. **Sources:** Resident health care records, including: progress notes, medication administration records, care plan, and smoking assessments; interviews with staff, including PSWs, nurses, and members of the home's management team; relevant internal investigation notes; the policy titled ""LTC – Recreational Consumption of Cannabis" and related tools: "LTC - Cannabis Assessment Tool", and the "LTC – Smoking/Vaping Contract Tool".	
[655]	

WRITTEN NOTIFICATION – POLICY TO PROMOTE ZERO TOLERANCE

NC#06 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 25 (1), LTCHA, 2007, s. 20 (1)

The licensee has failed to ensure that a written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Specifically, the policy titled "Resident Non-Abuse Program" was not complied with.

According to the above-noted policy:

- Anyone who becomes aware of or suspects neglect of a resident must immediately report that information to the Executive Director (ED), or to the most senior supervisor on shift; and,
- If there is any allegation towards a staff member, they will be suspended on administrative leave with pay immediately until an investigation is complete.

Rationale and Summary

A) FLTCA, 2021, s. 25 (1)

On a specific date, the Executive Director (ED) became aware of an allegation of neglect made by and individual who had been working in the home, related to the care of a resident by a specific PSW. The allegation was related to an incident that occurred approximately two weeks prior.

With regards to this incident, the licensee failed to ensure that the above-listed policy was complied with when:

1. A PSW was permitted to work during an on-going investigation related to the incident, in which the same PSW allegedly neglected a resident.

During an interview, the accused PSW indicated to Inspector #655 that they had been asked to work on a different home area; and, did so – one day after the ED became aware of an allegation of neglect against the same PSW.

One day after the PSW had been asked to work on a different home area, the ED indicated that the internal investigation into the incident was on-going; but, that the staff member had returned to work as described above, in order to fulfill a staffing need.

2. When staff did not comply with internal reporting procedures, as stated in the above referenced policy.

Over the course of the inspection, it was determined that an individual had reported their concerns pertaining to the care of the resident by the PSW to two different nurses.

During an interview, one of the nurses recalled that the individual had reported to them that the resident was not being provided with specified care when required. The nurse indicated to Inspector #655 that when the concerns were reported to them – almost two weeks ago, they had advised the individual to report the allegation to the ED and the Director of Care (DOC), but that the individual was not comfortable doing so. The nurse indicated that as an RPN, they would be required to report such a concern to the ED; but, they were unsure whether the same procedure applied to the individual who had reported the concern to them.

The licensee failed to comply with their written policy to promote zero tolerance of abuse and neglect of residents when the PSW who allegedly neglected a resident was permitted to work during an on-going investigation; and, when a nurse failed to report the incident of alleged neglect to the ED or DOC immediately. Based on the allegations made, these actions placed the resident and other residents at risk for potential harm.

Sources: internal investigation notes related to the incident of alleged neglect; a related critical incident report; relevant policies including the policy titled “Resident Non-Abuse Program”, and others; resident health care records; and interviews with staff including: PSWs, nurses, members of the home’s management team, and others.

B) LTCHA, 2007, s. 20 (1)

The Director was informed of an incident in which it was alleged that a PSW had abused a resident. According to the critical incident report, the incident was not reported using the after-hours line.

During an interview, the accused PSW was described by another staff member as having been verbally and physically abusive toward a resident. According to this staff member, they had witnessed the incident occur. During the same interview, the staff member indicated that the incident should have been reported immediately.

During the inspection, Inspector #655 reviewed the home’s internal investigation notes related to the above-noted incident. According to the notes, a short time after the staff member witnessed that incident, they reported to a nurse that the accused PSW was “rough” when providing care to the resident; but, did not elaborate.

During an interview, the ED indicated to Inspector #655 that initial report to the nurse lacked sufficient details; and therefore was not reported by the nurse internally until additional

information had been provided at the end of the shift. As such, the accused PSW continued to work – and provide care to residents - for the remainder of their shift on the day of the incident. According to the ED, the above-described allegations were substantiated by the long-term care home's internal investigation. The licensee's written policy to promote zero-tolerance of abuse and neglect of residents was not complied with when an incident of witnessed staff-resident abuse was not reported immediately in accordance with the licensee's internal reporting procedures. **Sources:** resident electronic heath care records, including progress notes; interview with a PSW and other staff, interview with members of the home's management team; review of relevant critical incident report and internal investigation notes; and, review of the policy titled "Resident Non-Abuse Program" and other relevant policies	
[655]	

WRITTEN NOTIFICATION – REPORTING CERTAIN MATTERS TO DIRECTOR

NC# 07 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 24 (1) 2

The licensee has failed to ensure that a person who has reasonable grounds to suspect abuse of a resident by anyone that resulted in harm, or a risk of harm to the resident, immediately reported the suspicion to the Director under the Long-term Care Homes Act, 2007.

In accordance with O. Reg. 79/10, physical abuse in the context of a resident-to- resident interaction means: the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary

According to a critical incident report, a resident sustained an injury after another resident exhibited physically aggressive behaviours towards them. In the incident report, it is indicated that the incident occurred one day before the critical incident report was first submitted to the Director under the Long-term Care Homes Act, 2007. On the critical incident report, it is indicated that the after-hours reporting line was not used to report the incident.

During an interview, a PSW indicated to Inspector #655 that the resident's mobility status had changed after the incident as a result of the injury.

In a progress note entered by an RPN, a noted change in the resident's mobility was described immediately following the incident. The resident was further described in the progress notes. by another RPN, as exhibiting signs of pain shortly after the incident.

During an interview, the ADOC indicated to Inspector #655 that such an incident should have been reported to the Ministry of Long-term Care immediately.

An incident of resident-to-resident abuse in which a resident sustained an injury, was not reported immediately when an injury was first suspected by an RPN.

Over the course of the inspection, another RPN indicated to Inspector #655 that they had not been familiar with reporting expectations until recently, despite having worked at the long-term care home for a number of years. During an interview, the DOC indicated to Inspector #655 that the registered practical nurses (RPNs) who work at the long-term care home are familiar with what type of incidents need to be reported; however, they would not be familiar with the procedures involved in ensuring an incident is reported.

Sources: resident health care records, including progress notes; a related critical incident report, and interviews with staff including a PSW, the ADOC, and the DOC.

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WRITTEN NOTIFICATION – DUTY TO PROTECT

NC#08 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 19 (1)

The licensee has failed to ensure that a resident was protected from abuse by a PSW.

Rationale and Summary

During an interview, a staff member recalled witnessing an incident of abuse directed toward a resident by a PSW. According to the staff member, the incident occurred near the beginning of the PSWs shift. The staff member further indicated that the incident should have been reported immediately, but that it wasn't because they were "in shock".

Internal investigation notes related to the above-described incident were reviewed by Inspector #655 during the inspection. In the investigation notes, the abusive behaviours exhibited by the PSW when providing care to the resident were described in further detail.

As described in NC #06, the staff member who witnessed the incident did not immediately report the details of what they had observed to the registered nurse (RN) on shift at the time of the incident, or to a member of the long-term care home's management team until the end of their shift. As such, the PSW continued to work- and to provide care to residents, for the remainder of their shift. In the internal investigation notes, it is further indicated that the RN did not report any information pertaining to the treatment of the resident by the PSW to the oncoming RN at the end of their shift; nor was there any indication that the resident had been assessed immediately following the incident. In the investigation notes, it is explained that the RN went to see the resident following the initial report of roughness during care, but did not want to wake them. On review of the resident's progress notes, there was no indication that the resident had been assessed in relation to the incident until approximately 20 hours after the incident occurred. According to the ED, the above-described incident of physical, verbal, and emotional abuse directed toward the resident by the PSW was substantiated as a result of the home's internal investigation. The licensee failed to ensure that a resident was protected from abuse by a PSW. **Sources:** resident electronic heath care record, including progress notes; interview with PSW and other staff, interviews members of the home's management team, review of a related critical incident report and internal investigation notes; and review of the policy titled Resident Non-Abuse Program", and other relevant policies.	
[655]	

WRITTEN NOTIFICATION – NURSING AND PERSONAL SUPPORT SERVICES

NC#09 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 11 (3) **The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty, and present in the home, at all times.** Pursuant to s. 11 (4) of the FLTCA, 2021, during the hours that an Administrator or Director of Nursing and Personal Care works in that capacity, they shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations.	

Rationale and Summary During an evening shift, Inspector #655 was unable to locate an RN in the long-term care home building. An RPN, who was working at the time, indicated that they were replacing the RN. During a follow-up interview, the same RPN confirmed that they work in place of an RN when required, taking on an "in-charge" role. According to the RPN, they had replaced the RN when an RN was not available to work on several different dates. The RPN indicated that on those dates they worked from 0600 hours until 1800 hours in that capacity. The RPN indicated that the DOC would have been in the building until 1630 hours on the specified dates, and that the DOC would have then been available by telephone if required. During the inspection, Inspector #655 reviewed the staffing lists and schedule. In addition to the above-identified dates, it was found that, according to the records provided, there was no RN, and an RPN had worked instead, on a specified night shift. The licensee failed to ensure that an RN was present in the home, at all times. As a result, there is potential that an RN would not be accessible onsite when required, thereby posing a risk of harm to residents. **Sources:** long-term care home's staff duty roster and daily staffing lists; records of posted and filled/vacant shifts; interviews with staff, including and RPN and DOC, observations.	
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WRITTEN NOTIFICATION – NURSING AND PERSONAL SUPPORT SERVICES

NC# 10 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 35 (3) a

The licensee has failed to ensure that the long-term care home's staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

Rationale and Summary

The long-term care home's staffing plan was not consistent with a resident's assessed care and safety needs.

As described in NC #06, the ED became aware of an allegation of neglect made by an individual who had worked in the home, related to the care of a resident by a PSW.

During an interview, the accused PSW indicated to Inspector #655 that on the day of the alleged incident, staff in all areas of the long-term care home were working short. During the inspection, a nurse recalled that on the day of the alleged incident, staff on the resident's home area were working "exceptionally" short of staff, and therefore could not provide care at the time of the request.

During an interview, the ED indicated that while the internal investigation into the above-described incident was on-going, the PSW had returned to work – and provided care to residents on another home area, in order to fulfill a staffing need.

Over the course of the inspection, staff reported to Inspector #655 that in addition to staffing shortages, the staffing complement on the second floor where the resident resides had been reduced completely by one PSW staff member.

During the inspection, staff also indicated to Inspector #655 that the had not received one-to-one supervision as required by the resident's plan of care, on a specified date (see NC #04). During an interview, a PSW indicated that there are times when the resident does not have one-to-one supervision in place for reasons related to staffing.

In addition to the above- described findings:

- A nurse described worsening behaviours among residents when staff work short. The nurse indicated that behaviours worsen when staff cannot respond to care needs in a timely manner.
- A nurse who is also a Behaviour Support Ontario (BSO) lead in the home indicated that between for a period of time, they were unable to perform their duties related to their BSO role because the long-term care home was "so short staffed".
- A finding of non-compliance has been issued in this report related to the licensee's failure to ensure 24-hour RN coverage. (see NC #09)

During the inspection, the DOC provided an overview of the long-term care home's staffing plan, including back-up plan. According to the DOC, staffing vacancies are not consistently filled by the staffing agency that the home currently works with.

Sources: interviews with multiple staff members regarding staffing concerns, including PSWs, RPNs, DOC, and ED, and Office Manager; a review of relevant records including staff duty roster, staffing lists, and vacancies; and, a review of the "LTC Staffing Data Collection" tool for the calculation period of January 1, 2022, to March 31, 2022.

[655]

Ministry of Long-Term Care
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Ottawa Service Area Office
347 Preston Street, Suite 420
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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. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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:

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

Ottawa Service Area Office
347 Preston Street, Suite 420
Ottawa ON K1S 3J4
Telephone: 1-877-779-5559
OttawaSAO.moh@ontario.ca

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
email: 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.