Ontario

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

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

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Original Public Report

Report Issue Date: May 17, 2023

Inspection Number: 2023-1046-0003

Inspection Type:
Complaint
Critical Incident System

Licensee: Heartwood Operating Inc.

Long Term Care Home and City: Heartwood, Cornwall

Lead Inspector	**Inspector Digital Signature**
Emily Prior (732)	Emily Prior Digitally signed by Emily Prior Date: 2023.05.23 14:00:18 -04'00'

Additional Inspector(s)
Severn Brown (740785)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 30 and 31, 2023 and April 3, 4, 12 -14, 17, and 18, 2023.
The inspection occurred offsite on the following date(s): April 5 and 17, 2023.

The following intake(s) were inspected:

- Complaint intake #00008694 regarding multiple resident care concerns, dining and snack service, and safety of the home
- Intake #00084746 (CI #2088-000008-23) related to an alleged medication incident
- Complaint Intake #00084760 regarding multiple resident care concerns, an alleged medication incident, dining and snack service, and safety of the home

NOTE: A WN related to FLTCA, 2021, s. 6 (9) (1) was identified in a concurrent inspection #2023-1046-002 (complaint intake #00002026) and issued in this report.

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

Continence Care
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management

Infection Prevention and Control
Safe and Secure Home
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Continence Care Program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 48 (1) 3.

1.The licensee has failed to ensure that for resident #002 the continence care and bowel management program to promote continence and ensure residents are clean, dry, and comfortable, was implemented.

Rationale and Summary
The ADOC and RAI Coordinator described that a continence assessment should be completed on admission and the licensee's Continence Care - Move In Procedure described that the nurse will complete a Continence Assessment on move in.

Resident #002 was admitted to the Long-Term Care Home in 2021. Inspector #732 reviewed resident #002's assessments and was unable to locate any Continent Assessments. The RAI Coordinator confirmed that there was no admission Continence Assessment completed for resident #002 and stated it should have been done.

As a result of not implementing the continence care and bowel management program; specifically, not completing an admission continence assessment, there is risk of harm to resident #002 as identification of casual factors, patterns, type of incontinence and potential to restore function with specific interventions was not assessed.

Sources: resident #002 Point Click Care documentation and assessments; Continence Care - Move In procedure Index: CARE2-O10-01, reviewed March 31, 2022; and interview with ADOC #109 and RAI Coordinator #116.
[732]

2.The licensee has failed to ensure that for resident #003 the continence care and bowel management program to promote continence and ensure residents are clean, dry, and comfortable, was implemented.

Rationale and Summary
The ADOC and RAI Coordinator described that a continence assessment should be completed on admission and the licensee's Continence Care - Move In Procedure described that the nurse will complete a Continence Assessment on move in.

Resident #003 was admitted to the Long-Term Care Home in 2019. Inspector #732 reviewed resident #003's assessments and noted that the first Continence Assessment was completed four months after admission. The RAI Coordinator confirmed that there was no admission Continence Assessment completed for resident #003 and stated it should have been done.

As a result of not implementing the continence care and bowel management program; specifically, not completing an admission continence assessment, there is risk of harm to resident #003 as identification of casual factors, patterns, type of incontinence and potential to restore function with specific interventions was not assessed.

Sources: resident #003 Point Click Care documentation and assessments; Continence Care - Move In procedure Index: CARE2-O10-01, reviewed March 31, 2022; and interview with ADOC #109 and RAI Coordinator #116.
[732]

WRITTEN NOTIFICATION: Plan of Care Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

1.The licensee has failed to ensure that the care set out in the plan of care for resident #001 and #004 was documented.

Rationale and summary
An allegation was received alleging that resident #001 and #004 did not receive baths for a nine day period in December 2022 and February 2023. Resident #004 stated they did not receive a bath for an extended period in both December 2022 and February 2023, however they could not specify the dates

they allege they did not receive a bath.

A review of resident #001 and #004's point of care (POC) documentation found two nine day periods without any documentation of either resident receiving a bath on two specified dates in December, 2022 and two specified dates in February, 2023. Director of Care (DOC) #101 and Personal Support Worker (PSW) #135 confirmed that there was no documentation in the POC documentation for the above dates.

PSW #135, who was working on the identified dates in December 2022 and February 2023, and is responsible for providing residents baths on the first floor, stated the residents received their baths, however they did not complete the necessary documentation. PSW #135 stated that resident baths or showers are to always be documented in the POC, no matter the kind of bath or shower, and no blank sections should exist in a resident's POC documentation. DOC #101 stated that PSWs who bathe residents are to document the baths in POC, and there should be no blank sections in the POC documentation.

Documentation of residents' care is essential to ensure clear communication of care and interventions is provided to all staff.

Sources
Medical records for Resident #001 and #004
Interviews with PSW #135 and DOC #101
Bath Schedule first floor Days January 2023
[740785]

2.The licensee has failed to ensure that resident #002’s continence care was documented.

Rationale and Summary
Resident #002’s plan of care indicated that the resident required total assistance for all toileting needs with two staff and required incontinence care for total functional bladder and bowel incontinence.

PSW #113 and #117 both indicated that toileting is documented each shift on Point of Care (POC).

POC documentation by PSW’s was reviewed for resident #002 for the months of March and April, 2023. The following dates and shifts contained no documentation related to continence care for the resident:
-Day shift: seven shifts in March, and five shifts in April.
-Evening shift: three shifts in March, and one shift April.
-Night shift: ten shifts in March , and two shifts in April.

The Associate Director of Care (ADOC) confirmed that PSW's are expected to document, at minimum, once per shift on a resident's continence care and that this is completed on POC. They further explained that no blank sections should exist in a resident's POC documentation for continence care.

By not ensuring resident's continence care is documented, there is risk of residents receiving inconsistent and improper continence care.

Sources: resident #002's plan of care; Point of Care documentation; and interview with PSW #113, PSW #117, ADOC #109, and other staff.
[732]

3.The licensee has failed to ensure that resident #003's continence care was documented.

Rationale and Summary
Resident #003's plan of care indicated that the resident had daily episodes of bladder/bowel incontinence related to decline in condition and to provide toileting upon request. It further indicated that the resident required two person physical assist for toilet use and used an incontinent product.

PSW #113 and #117 both indicated that toileting is documented each shift on POC.

POC documentation by PSW's was reviewed for resident #003 for the months of March and April, 2023. The following dates and shifts contained no documentation related to continence care for the resident:
-Day shift: thirteen shifts in March, and two shifts in April.
-Evening shift: three shifts in March, and one shift in April.
-Night shift: eight shifts in March, and five shifts in April.

The ADOC confirmed that PSW's are expected to document, at minimum, once per shift on a resident's continence care and that this is completed on POC. They further explained that no blank sections should exist in a resident's POC documentation for continence care.

By not ensuring resident's continence care is documented, there is risk of residents receiving inconsistent and improper continence care.

Sources: resident #003's plan of care; MDS assessment; Point of Care documentation; and interview with PSW #113, PSW #117, ADOC #109, and other staff.
[732]

4.The licensee has failed to ensure that resident #001's continence care was documented.

Rationale and Summary
A continence assessment completed for resident #001 in March, 2023 indicated that the resident was often continent, but sometimes incontinent, required physical assistance to access the toilet, and used an incontinent product.

PSW #113 and #117 both indicated that toileting is documented each shift on POC.

POC documentation by PSW's was reviewed for resident #001 for the months of March and April, 2023. The following dates and shifts contained no documentation related to continence care for the resident:
-Day shift: thirteen shifts in March, and two shifts in April.
-Evening shift: three shifts in March.
-Night shift: ten shifts in March, and four shifts in April.

The ADOC confirmed that PSW's are expected to document, at minimum, once per shift on a resident's continence care and that this is completed on POC. They further explained that no blank sections should exist in a resident's POC documentation for continence care.

By not ensuring resident's continence care is documented, there is risk of residents receiving inconsistent and improper continence care.

Sources: resident #001 continence assessment; Point of Care documentation; and interview with PSW #113, PSW #117, ADOC #109, and other staff.
[732]

5.The licensee failed to ensure that the care provided as set out in resident #009's plan of care was documented.

Resident #009's care plan, which was last reviewed in April 2022, states that the resident requires support to provide toileting as evidenced by inability to complete task safely and independently.

Upon review of resident #009's Point of Care documentation for continence care for June 2022, no documentation for continence care in the following instances were determined: five day shifts; two evening shifts; and thirteen night shifts.

According to PSW #108, PSWs are responsible for documenting on resident's continence and documentation is required every shift. PSW #108 also stated that no blank sections should exist in a resident's Point of Care

documentation for continence care.

ADOC #109 stated that PSWs are expected to document, at minimum, once per shift on residents' continence care, and that no blank sections should exist in a resident's Point of Care documentation for continence care.

By not ensuring that Point of Care documentation was completed for resident #009's continence care, residents are at risk of not being provided consistent continence care.

Sources:
Resident #009's Plan of Care
Resident #009's Point of Care Documentation June 2022
Interviews with PSW #108 and ADOC #109
[740785]

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)

The licensee has failed to ensure that resident #001, who is incontinent at times, had an individualized plan to promote and manage bowel and bladder continence based on an assessment, as part of their plan of care.

Rationale and Summary
Resident #001's continence assessment from March, 2023, and interview with PSW #113 described resident #003 as continent, with occasional incontinence. The licensee's Continence Care Program Policy specified that residents have individualized plans of care, and that the interdisciplinary care team assess all residents using a clinical assessment instrument and develop a personalized plan of care.

The ADOC explained that staff access information on resident toileting, and continence status and care, from the resident's care plan and/or kardex. Inspector reviewed resident #001's two most recent care plans and kardex and was unable to locate an individualized plan to promote and manage bowel and bladder continence for resident #001. The ADOC confirmed that resident #001's toileting information was not in their care plan and that it should be.

With no individualized plan of care related to resident incontinence, there is risk of harm to resident #001 as staff may not be aware of how to promote and manage the resident's bowel and bladder continence.

Sources: Resident #001 Continence Assessment, March, 2023; resident #001 care plan; resident #001 current care plan; resident #001 current Kardex; Continence Care Program Policy, Index: CARE2-P10, reviewed March 31, 2022; and interview with PSW #113, ADOC #109, and other staff.
[732]

WRITTEN NOTIFICATION: Maintenance Services

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (a)

The licensee has failed to ensure that procedures to ensure mechanical lifts are kept in good repair were implemented.

Rationale and Summary
The Executive Director explained that staff are to check that all lifts are in good working order by using the Start Up Inspection Checklist at the start of every shift. Staff are to check items off the checklist and initial at the bottom when complete. Furthermore, the licensee's Equipment Pre Start Procedure described that employees complete pre-start inspection at the first use of each shift. Immediately report any defects to Manager and follow LockOut -TagOut procedures, if appropriate.

Inspector #732 reviewed the Start Up Inspection Checklist for both the Hoyer lift and Sara lift on the One North Unit for October 2022. The following dates and shifts were left blank:
-Hoyer lift: eight shifts.
-Sara lift: seven shifts.

Inspector #732 reviewed the Start Up Inspection Checklist for both the Hoyer lift and Sara lift on the One North Unit for April 2023. The following dates and shifts were left blank:
-Hoyer lift: five shifts.
-Sara lift: nine shifts.

The Executive Director explained that if the Start Up Inspection Checklist is left blank, it is assumed staff did not check the mechanical lifts.

When the mechanical lifts are not checked to ensure they are in good working order there is risk of harm to residents as they could be injured while in the lifts during transfers.

Sources: Equipment Pre Start Procedure, Index: OHS2-O60.04, reviewed October 31, 2022; Start Up Inspection Checklists 1N Unit, October 2022; Start Up Inspection Checklists 1N Unit, April 2023; Interview with Executive Director #100 and other staff.
[732]

WRITTEN NOTIFICATION: Maintenance Services

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (k)

The licensee has failed to ensure that procedures were developed and implemented to ensure that the water temperature was monitored once per shift in random locations where residents have access to hot water.

Rationale and Summary
The Executive Director described that the home monitors water temperatures to resident areas using thermometers. They indicated that this is completed by registered staff on night shift and housekeeping staff on day shift, and that it is documented on the Heartwood Water Temperature Chart and Heartwood Supervisor or Designate Night Building Checklist.

Inspector reviewed the above charts and checklist and noted that on evenings the water temperature was not monitored in random locations where residents have access to hot water. The Executive Director confirmed that water temperatures were not taken on evening shift.

There is risk of residents suffering burns as a result of the water temperature not being monitored on evening shift.

Sources: Heartwood Water Temperature Chart completed by housekeepers on day shift April 2023; Heartwood Water Temperature Chart completed by Nursing staff on nights April and March 2023; Heartwood Supervisor or Designate Night Building Checklist March 2023; and interview with Executive Director, and other staff.
[732]