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

**Ottawa District**
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

# Original Public Report

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| **Report Issue Date:** August 22, 2023 |
| **Inspection Number:** 2023-1046-0004 |
| **Inspection Type:**<br>Complaint<br>Follow-Up<br>Critical Incident System |
| **Licensee:** Heartwood Operating Inc. |
| **Long Term Care Home and City:** Heartwood, Cornwall |

| **Lead Inspector** | **Inspector Digital Signature** |
|---|---|
| Severn Brown (740785) | Severn Brown Digitally signed by Severn Brown Date: 2023.08.22 12:12:46 -04'00' |

**Additional Inspector(s)**

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 4, 5, 6, 7, 10, 11, 2023

The following intake(s) were inspected:

- Intake: #00015676 -IL-08160-AH Resident/2088-000038-22 Alleged staff to resident neglect of care.
- Intake: #00018437 -2088-000002-23 Resident fall with injury causing change in condition.
- Intake: #00021518 -2088-000006-23 Unexpected death. Ruled accidental by coroner. Multiple falls.
- Intake: #00087698 -IL-13060-OT Complainant alleges neglect.
- Intake: #00088126 -Follow-up #: 1 - O. Reg. 246/22 - s. 12 (1) 3. Order related to Safe and Secure - Doors in a Home. Compliance Due Date was June 30, 2023.
- Intake: #00088346 -IL-13371-AH/2088-000012-23 - Witnessed fall causing injury and change in condition.
- Intake: #00088897 -IL-13666-OT Complaint from staff member regarding resident fall from lift.
- Intake: #00089563 -2088-000015-23 Unwitnessed fall causing injury and change in condition.

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1046-0002 related to O. Reg. 246/22, s. 12 (1) 3. inspected by Severn Brown (740785)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Plan of Care

**NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

Rationale and summary
A resident sustained a fall which resulted in a change of condition. The resident's care plan states that a floor alarm must be set up and activated when the resident is in bed or in their wheelchair. During the inspection of this incident the resident was observed in their room, the resident was in bed, no floor alarm was seen by the inspector. A Personal Support Worker (PSW) was found and asked about how the floor alarm was supposed to be set up. The floor alarm was on the resident's bedside table, not turned on or setup as per the PSW. The PSW stated that the resident is to have a floor alarm setup at the foot of their bed or in front of their wheelchair when they are in their bed or their chair.

By not ensuring the resident's floor alarm was setup, staff would not be made aware if the resident was attempting to get up without assistance from staff, placing them at risk of fall and subsequent injury.

Sources:
Interview with PSW;
Observation of the resident;
The resident's plan of care.

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B) The licensee has failed to ensure that resident plan of care related to Infection Prevention and Control (IPAC) was implemented as written.

Rationale and summary
A Registered Nurse (RN) RN was seen providing direct care to a resident. The RN was not observed wearing any Personal Protective Equipment (PPE) to provide care to the resident. Outside the resident's door, isolation signs are present with a PPE dispenser. Per the resident 's Kardex, all staff who make provide care to the resident must wear the appropriate PPE. The IPAC manager stated that staff members must wear appropriate PPE when providing care to the resident.

By not ensuring that the RN wore appropriate PPE while providing care to the resident , the RN put themself and others in the home at risk of contracting and/or transmitting a communicable disease.

Sources:
Observation of the RN with resident;
Interview with the IPAC Manager;
the resident's Kardex.

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## WRITTEN NOTIFICATION: Skin and wound care

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)

The licensee has failed to ensure that a skin assessment was performed of a resident when they returned from hospital.

Rationale and summary

A resident returned from hospital after being diagnosed with an injury causing a change in their condition.

On chart review, no skin assessment was documented in the resident's chart after they had returned from hospital. The Executive Director (ED) confirmed that no skin assessment was documented in the resident's chart. The ED stated that residents must have a head-to-toe assessment performed when they return from hospital. The RN stated that residents must have a skin assessment performed when they returned from hospital and that the skin assessment must be recorded in the home's electronic charting system.

By not ensuring a skin assessment was performed for the resident when they returned from hospital, the resident was placed at risk of having potentially unidentified skin integrity impairment.

Sources:
Interviews with an RN and the ED;
The resident's medical record.

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## WRITTEN NOTIFICATION: Resident repositioning

**NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 55 (2) (d)

The licensee has failed to ensure that a resident, who is dependent on staff for repositioning, was repositioned every two hours.

Rationale and summary
A PSW allegedly failed to provide care to resident while assigned to a resident during their shift. The home's subsequent investigation substantiated the lack of care for the resident.

The Executive Director stated that the resident was not provided required care, including repositioning every two hours, during the specified shift. Another PSW at the home stated that the resident requires turning and positioning every two hours over night and that the turning and positioning must be documented. During the home's internal investigation, the PSW acknowledged that care was not performed as the resident had responsive behaviours. The ED stated that the PSW should have sought help from their colleagues that night to ensure that the resident was provided care. On review of the point of the resident's medical record, the turning and positioning documentation sections were left blank on the specific shift.

By not ensuring that the resident was turned and positioned every two hours, the resident was placed at risk of developing impaired skin integrity.

Sources:
Interviews with the ED and a PSW;
Investigation notes performed by the ED;
The resident care plan and medical record.

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## WRITTEN NOTIFICATION: Continence care

**NC #004 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 a resident's individual incontinence plan was implemented.

Rationale and summary
A PSW allegedly failed to provide care to resident while assigned to a resident during their shift. The home's subsequent investigation substantiated the lack of care for the resident.

The resident was found that they were not provided continence care the morning after a specific night shift by other staff members on the day shift. The resident's care plan states that the resident requires extensive or total care for hygiene and that the resident will remain clean and odour free. The overnight documentation for the resident's continence care was left blank on the specified night shift. During the home's investigation, the PSW assigned to the resident that night shift acknowledged they did not perform care as the resident was exhibiting responsive behaviours. The ED stated that the PSW did not ask for help from any colleagues to help perform care for the resident as they should have done. Another staff PSW stated that the resident needs significant help from one to two staff members to perform incontinence care.

By not performing incontinence care for a resident, the resident was put at increased risk of skin integrity impairment and general discomfort.

Sources
Interview with ED and a PSW;
The resident's medical record;
The resident's plan of care.

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## COMPLIANCE ORDER CO #001 Safe transfer techniques

**NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.**
Non-compliance with: O. Reg. 246/22, s. 40

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The licensee shall:

A) Provide re-training to a Personal Support Assistant (PSA) and a Personal Support Worker (PSW) on the safe use of all types of mechanical lifts used in the home;

B) For a period of four weeks, audit all fall incidents that occur in the home to assess if a mechanical lift was involved. If a mechanical lift was involved in any fall incident, provide retraining on the safe use of mechanical lifts to all staff directly involved in the fall incident.

C) A written record must be kept for the requirements in (A) and (B).

**Grounds**
The licensee failed to ensure that a PSA and PSW used safe transferring techniques when mechanically lifting a resident.

A resident sustained a fall from their sling while being mechanically lifted by a PSA and a PSW. An RPN, RN, and the Assistant Director of Care (ADOC) all stated that the resident was not properly secured into their sling prior to being lifted. An RPN documented in their post-fall assessment that the front right clip for the resident's sling was not properly secured to the lift. The RN documented in the incident report that resident sling's front right clip was not properly secured to the lift. The PSW stated that they thought the resident's sling had been checked to be secured to the sling, however the sling did come undone and the resident fell to the floor.

By not ensuring that the resident's sling was properly secured to the mechanical lift, the resident fell from the sling resulting in minor injuries, and was placed at risk of sustaining additional injuries.

Sources:
Interviews with a PSW, an RPN, an RN, and the ADOC;
The resident’s medical record;
The resident's Risk management incident report.

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**This order must be complied with by** September 15, 2023

## COMPLIANCE ORDER CO #002 Falls prevention and management

**NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.**
Non-compliance with: O. Reg. 246/22, s. 54 (1)

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The licensee shall:

A) Provide training to two RPNs on the correct implementation of the Falls Prevention and Injury Reduction program related to the Head Injury Routine (HIR);

B) Conduct audits of fall incidents in the home for a period of four weeks to ensure that the HIR was initiated and completed as required by the HIR policy;

C) If deviation from the HIR policy is determined during the course of the required audits, the relevant staff members must be provided education and training on the correct implementation of the Head Injury Routine.

D) A written record must be kept of all the requirements for (A), (B), and (C).

**Grounds**
The licensee has failed to ensure that the Fall Prevention and management program was complied with for a resident.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to have a falls prevention and management program to reduce the incidence of falls and the risk of injury, and it must be complied with.

Specifically, two RPNs did not comply with the policy Falls Prevention and Injury Reduction, Head Injury Routine which was included in the licensee's Falls Prevention and Management Program and the Neurological Flowsheet included in the Falls Prevention and Injury Reduction policy.

According to the neurological flowsheet as part of the Falls Prevention and Injury Reduction program, residents demonstrating a significantly altered level of consciousness (LOC) below a specified threshold must be sent to hospital immediately. Per CARE5-O10.06: Falls Prevention and Injury Reduction, the physician must be notified if there is a change in a resident's neurological status.

According to the documented assessments performed by an RPN, a resident demonstrated a significantly altered LOC for a sustained time period below the specified threshold. The RPN stated that the resident was not sent to hospital but should have been. The resident's physician stated that they were unaware of the resident's altered neurological status which significantly differed from the resident's normal cognition. The ED stated that residents are supposed to go to hospital if their LOC is at or below the specified threshold unless clearly indicated in the resident's goals of care. The ED stated there was no indication for the resident not to be sent to hospital based on their goals of care.

By not ensuring that the resident's physician was made aware of resident change in neurological status and by not sending the resident to hospital, the resident was placed at risk of not being provided with medical assessment and evaluation.

Sources:
Interviews with an RPN, a Physician, and the ED;
The resident's medical record;
CARE5-O10.06: Falls Prevention and Injury Reduction, Head Injury Routine.

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**This order must be complied with by** September 15, 2023

## 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;
(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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) 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:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) 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:

**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
e-mail: 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.