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

Report Issue Date: October 27, 2023

Inspection Number: 2023-1046-0005

Inspection Type:
Complaint
Critical Incident
Follow up

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: 2023.10.27 09:55:37 -04'00'

Additional Inspector(s)
Shevon Thompson (000731)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 18, 19, 20, 21, 22, 25, 26, 27, 28, 29, 2023

The following intake(s) were inspected:

- Intake: #00088125 - Follow-up #: 1 - FLTCA, 2021 - s. 6 (7) Order related to Plan of Care. Original Compliance Due Date (CDD) was June 30 2023. LTC home requested an extension. New CDD is August 30, 2023.
- Intake: #00088127 - Follow-up #: 1 - O. Reg. 246/22 - s. 102 (2) (b) Order related to Infection Prevention and Control. Original Compliance Due Date (CDD) was June 30 2023. LTC home requested an extension. New CDD is August 30, 2023.
- Intake: #00093815 - Follow-up #: 1 - O. Reg. 246/22 - s. 40 Order related to transfer and positioning techniques. Compliance Due Date (CDD) September 15, 2023.
- Intake: #00093816 - Follow-up #: 1 - O. Reg. 246/22 - s. 54 (1) Order related to the falls prevention and management program. Compliance Due Date (CDD) September 15, 2023.
- Intake: #00088298 - IL-13320-OT - Complainant with concerns regarding resident elopement from the home.
- Intake: #00093270 - IL-15787-OT Complainant reporting alleged abuse of resident by family

- Intake: #00096878 - IL-17460-OT Complaint related to two injuries to the same resident causing a change in condition.
- Intake: #00090872 - 2088-000016-23 - Fall of resident resulting in injury causing change in condition.
- Intake: #00091920 - IL-15171-AH/2088-000017-23 Improper transfer of resident by staff causing injury with a change in condition.
- Intake: #00092769 - 2088-000019-23 Alleged staff to resident neglect.
- Intake: #00093215 - 2088-000021-23 Alleged family to resident abuse with injury
- Intake: #00096004 - 2088-000023-23 - Unwitnessed fall of resident causing injury and a change in condition.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2023-1046-0002 related to FLTCA, 2021, s. 6 (7) inspected by Severn Brown (740785)

Order #003 from Inspection #2023-1046-0002 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Severn Brown (740785)

Order #001 from Inspection #2023-1046-0004 related to O. Reg. 246/22, s. 40 inspected by Severn Brown (740785)

Order #002 from Inspection #2023-1046-0004 related to O. Reg. 246/22, s. 54 (1) 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
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management
Resident Charges and Trust Accounts

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance of abuse or neglect of residents

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with. Specifically, the licensee failed to ensure that a Personal Support Assistant (PSA) and a Personal Support Worker reported an incident of improper care immediately to their supervisors as required by the home's policy.

Summary and rationale
An investigation by the home into an injury a resident sustained determined that the resident was not transferred according to their assessed transfer status. A PSA and a PSW both stated they witnessed another PSW incorrectly transfer a resident but did not report the incident to the nurse in charge. The disciplinary letters for the PSA and PSW both state that the staff members were aware that the resident was inappropriately lifted, and they should have reported the incident immediately. The Executive Director (ED) stated it was only through their subsequent investigation into the incident that the cause of the injury was determined and that the PSA and PSW should have reported the incident to the nurse in charge immediately so that the incident could be immediately reported to the Director and other appropriate authorities.

Procedure ADMIN-O10.01 Resident non-abuse: Mandatory reporting of resident abuse or neglect, states that any person who has reasonable grounds regarding neglect of a resident must immediately report the incident to the person in charge who is the nurse on duty.

By not ensuring that the PSA and PSW complied with the home's written policy to promote zero tolerance of abuse and neglect of residents, the resident was put at risk of having delayed nursing assessment, care, and regulatory oversight to ensure their safety.

Sources:
Interviews with a PSA, a PSW, and the ED;
Disciplinary letters for the PSA and PSW;
Procedure ADMIN-O10.01 Resident non-abuse, Mandatory reporting of resident abuse or neglect, last

reviewed March 31, 2023.

[740785]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a person who had reasonable grounds to suspect the abuse of a resident by anyone, that resulted in harm or risk of harm to a resident, immediately reported the suspicion and the information upon which it was based to the Director.

Summary and rationale
Review of Critical Incident Report (CIR) #2088-000021-23 reported an incident of alleged abuse occurred between a family member and a resident.

A review of Heartwood's Policy, Resident Non-Abuse Program, with review date March 31, 2023 the procedure stated "where any person has reasonable grounds to suspect that any of the following has occurred or may occur, such person must immediately verbally report the suspicion and the information upon which it is based to the person in charge (i.e. the nurse on duty ("the Nurse")). They will together immediately report this to their legislative Authority as per legislation. (Ont. - Director of the MOHLTC in accordance with Critical Incident Reporting Requirements). This would apply to any of the following: 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 a Resident.

In an interview with an RN, they stated that if there was suspected abuse or neglect the Director of Care was to be notified. If the Director of Care was not in the building the nurse that was present would call the ministry with the information.

Failing to ensure that the Director was informed immediately of this incident placed the residents at risk of not receiving appropriate follow-up.

Sources:
Critical Incident Report #2088-000021-23;
Interview with the Director of Care (DOC), Interview with the RN;
Heartwood's Policy, Resident Non-Abuse Program review date March 31, 2023.

[000731]

WRITTEN NOTIFICATION: Retraining

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)

The licensee has failed to ensure that a person who has received training, receive retraining at times or at intervals provided for in the regulations.

In accordance with FLTCA 82 (2) 11. Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in any other areas provided for in the regulations. Per, O. Reg. 246/22 s.259. (1) 2. For the purposes of paragraph 11 of subsection 82 (2) of the Act, the following are additional areas in which training shall be provided: Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities. Per, O. Reg s. 260. (1) the intervals for the purposes of subsection 82 (4) of the Act are annual intervals.

Summary and rationale
In an interview with a Registered Practical Nurse (RPN) they were not sure if they had received Falls prevention and Lift and transfer training in the last year. In an interview with Resident Service Coordinator #119, they stated that RPN #104 had not completed the SALT (Safe Lift and Transfer) training during the last year.

Review of the home's mandatory training tracking spreadsheet titled; Worksheet for Tracking Staff Completion of Annual Mandatory Training, dated September 26, 2023, page 1, showed RPN #104 had not completed the SALT. SALT is the home's Safe Lift and Transfer training/retraining program.

The residents, receiving care from the RPN, are placed at an increased risk for improper transfer when retraining on the safe and correct use of lifts are not completed.

Sources:
The home's Worksheet for Tracking Staff Completion of Annual Mandatory Training;
Interview with an RPN and the Resident Service Coordinator.

[000731]

WRITTEN NOTIFICATION: Skin and wound care

NC #004 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 upon a resident's return from hospital.

Summary and rationale
A resident returned from an emergency visit to hospital on a documented date. An RN stated that skin assessments must be performed when a resident returns from all hospital visits. The RN confirmed that they were working on the specified date when the resident returned from hospital but stated they did not perform a skin assessment. The RN reviewed the documentation for resident with the inspector #740785 and no skin assessment documentation was found on that day.

By not ensuring a skin assessment was performed on a resident when they returned from hospital, the resident was put at risk of having unassessed skin integrity impairments.

Sources:
Interview with an RN;
Record review of the resident's electronic documentation with an RN.

[740785]

WRITTEN NOTIFICATION: Responsive behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.

The licensee has failed to ensure that written strategies to prevent and minimize a resident's responsive behaviours were developed.

Summary and rationale
A resident was found outside in the home's parking lot on a documented dated. A PSW, an RPN, and the Associated Director of Care all stated that the resident exhibited exit seeking behaviour and would attempt to leave via the elevator on the second floor. The ADOC stated that the resident was not safe to

be on the first floor or outside unattended. Record review was performed by the inspector with an RPN and the ADOC, there was no indication in the resident's written care plan before or after the incident that the resident had exit seeking responsive behaviours and no written strategies were documented related to elopement prevention of the resident.

By not ensuring that interventions were in place for the resident related to their exit seeking behaviours, the resident eloped briefly from the home and was placed at risk of injury by being outside without adequate supervision.

Sources:
Interviews with PSW, RPN, and ADOC;
Review of the resident's electronic chart.

[740785]

WRITTEN NOTIFICATION: Infection prevention and control

NC #006 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 implement the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes. Specifically, the licensee failed to ensure that staff performed routine practices of hand hygiene, as required in section 9.1 (b) of the IPAC standard, before and after initial resident contact.

Summary and rationale
A PSW was observed coming out of a room, getting a drink for a resident and handing the resident a drink without performing any hand hygiene. On another date a different PSW was observed in the north end hallway, first floor, providing a resident fluid then proceeding into a room and assisting a resident without performing hand hygiene. A Personal Support Assistant (PSA) was observed providing a resident a snack after coming out of a room without performing any hand hygiene. Inspector #000731 observed a PSA going between multiple rooms for the purpose of snack pass without performing any hand hygiene.

the IPAC Manager stated that all staff are required to perform hand hygiene before and after any contact with each resident. Procedure IPC2-O10.04 Routine Practices and Additional Precautions, as part of the home's IPAC program, states that employees will perform hand hygiene before, between, and

after activities that may result in cross-contamination.

By not ensuring that staff members were performing hand hygiene between different residents, staff placed residents, themselves, and others at risk of spreading infectious disease.

Sources:
Observations of two PSWs and a PSA;
Interview with the IPAC Manager;
Procedure IPC2-O10.04 Routine Practices and Additional Precautions last reviewed March 31, 2023.

[740785]

The licensee has failed to implement the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes. Specifically, the licensee failed to ensure that section 9.1 of the IPAC Standard was implemented for point-of-care signage indicating enhanced IPAC control measures are in place.

Summary and rationale
No signage was observed on a resident's door related to their additional contact precautions. The resident's electronic chart indicated that the resident was on additional isolation precautions. The IPAC Manager was made aware of the lack of signage and stated the resident should have signage on their door related to their additional precautions requirement.

By not ensuring that signage was present indicating the type of additional precautions for the resident, staff, residents, and visitors are not made aware of a resident on additional isolation precautions.

Sources:
Observations of a resident's room and front door;
the resident's electronic chart;
Interview with the IPAC Manager.

[740785]

WRITTEN NOTIFICATION: Licensees who report investigations

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (3)

The licensee has failed to submit a final report of a Critical Incident Report (CIR) submitted to the Director within 21 days as specified in the MLTC Reporting Requirements for LTC Homes.

Per Ministry of Long-Term Care Reporting Requirements for LTC Homes, dated October 2022 (updated June 2023); If the licensee cannot provide the material listed above within 10 days, the licensee must submit a preliminary report with the information available. The final report must then be submitted within 21 days of becoming aware of the incident, or earlier if required by the Director.

Summary and rationale
Review of CIR #2088-000019-23 showed an incident occurred on a specified date. The Critical Incident Report was amended on the next day. Analysis and follow-up in the CIR were listed as an ongoing investigation and education for staff. No further update for the completion of the investigation.

In an interview with the Director of Care (DOC) they stated they had completed the investigation but had not finalized the CIR, which was past the 21 day window required for reporting the result of a home's investigation to the Director.

There was no impact or risk to the resident as a result of the licensee not submitting a final report on the incident of alleged abuse or neglect.

Sources:
MLTC Critical Incident Systems Report #2088-000019-23;
Interview with the DOC.

[000731]

COMPLIANCE ORDER CO #001 Transferring and positioning techniques

NC #008 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 prepare, submit and implement a plan to ensure compliance with [FLTCA, 2021, s. 155 (1) (b)]:

The licensee shall prepare, submit and implement a plan to ensure staff are using safe transferring and positioning techniques for residents who require mechanical lifts. The plan shall include but is not limited to:

-How staff will evaluate and ensure compliance with all applicable policies related to the mechanical lifting of residents and how it will be completed;

-The person(s) responsible for monitoring and evaluating that staff are using safe lifting and transferring techniques for residents who require a mechanical lift;

-The person(s) responsible for implementing an action plan if monitoring and evaluation demonstrates that the policy for safe mechanical lifts and transfers is not complied with;

-Actions taken to ensure that the home is brought back into compliance should the home's monitoring and evaluation of lifts and transfers determine non-compliance with the applicable policies and procedures; and

-How the home will record the monitoring, evaluations and actions taken to ensure compliance with its compliance plan related to safe lifts and transfers. A documented record must be kept of all work completed as part of the plan.

Please submit the written plan for achieving compliance for inspection #2023-1046-0005 to Severn Brown (740785), LTC Homes Inspector, MLTC, by email to ottawadistrict.mltc@ontario.ca by November 1, 2023.

Please ensure that the submitted written plan does not contain any Personal Information/Personal Health Information.

Grounds
The licensee has failed to ensure that a Personal Support Worker (PSW) used safe transferring and positioning techniques when transferring a resident.

Summary and Rationale
A resident was diagnosed with an injury causing a change in condition after exhibiting pain and requiring emergency assessment. The home's subsequent investigation into the injury determined that a PSW had manually lifted the resident by themself two days prior to the diagnosis.

The resident's written care plan states that the resident is to be mechanically lifted with two staff members present. A Personal Support Assistant (PSA) and a Personal Support Worker (PSW) both stated they witnessed another PSW perform a one-person manual lift on the resident on the specified date. A Registered Nurse (RN) documented that the resident exhibited symptoms of an injury causing a change in condition and the resident was sent to hospital for assessment of the symptoms. The Executive Director (ED) stated the home's investigation into the injury determined that a PSW had improperly manually lifted the resident when the resident required a mechanical lift.

By not ensuring that the resident was lifted mechanically, as required in their written care plan, the resident was found to have sustained an ankle fracture as a result of being manually lifted by a PSW and has subsequently had a change in their condition due to the improper lift.

Sources:
Interviews with a PSA , a PSW, and the ED;
The resident's electronic chart and care plan;
Disciplinary letter for the PSW.

[740785]

This order must be complied with by December 8, 2023

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Prior non-compliance with O. Reg 246/22 s. 40, resulting in CO #001 from inspection #2023-1046-0004, issued on August 3, 2023.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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.