Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 22, 2018	2018_690130_0001	000052-18	Resident Quality Inspection

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

Long-Term Care Home/Foyer de soins de longue durée

The Village of Wentworth Heights
1620 Upper Wentworth Street HAMILTON ON L9B 2W3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

GILLIAN HUNTER (130), AILEEN GRABA (682)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): January 3, 4, 5, 8, 9, 2018.

The following inspections were conducted concurrently with this RQI:

Onsite Inquiries: 009946-17, 021386-17 and 027249-17 related to Prevention of Abuse, and Follow-up : 009352-17 related to Falls Management.

During this inspection the home was toured, clinical records and relevant policies and procedures were reviewed, staff and residents were interviewed.

During the course of the inspection, the inspector(s) spoke with the General Manager, Director of Care, Associate Director of Care, Resident Assessment Instrument (RAI) Coordinator, Registered staff, Personal Support Workers (PSW), President of Residents' Council, residents and families.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 49. (2)	CO #001	2017_546585_0007	130

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

A) During a tour of the home, multiple unlabelled used stick deodorants, used bar soap and an unlabelled soiled hairbrush, were found in baskets in the Spa on an identified home area. There were unlabelled used stick deodorants and combs and new and used unlabelled combs stored together in a basket found in the Spa on a second identified home area.

The DOC confirmed in an interview, that all personal care items were to be hygienically stored and labelled for individual use. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A) The Quarterly Minimum Data Set (MDS) Assessment completed for resident #059 on a specified date in 2017, revealed under Section M Skin Condition, that the resident had two areas of impaired skin integirity. The Resident Assessment Protocol (RAP) competed during the same assessment period also revealed the resident had two areas of impaired skin integrity. Subsequent skin assessments completed on four later dates in 2017, indicated the resident had no impaired skin; however, different skin assessments completed during the same time period identified two areas of impaired skin integrity.

The written plan of care, revised in 2017, revealed the resident did have impaired skin integrity which required treatment.

The RAI Coordinator confirmed the resident did in fact have impaired skin integrity during the assessment periods in 2017 and that the skin assessments completed during this time period were not integrated, consistent with and nor did they complement each other. (Inspector #130).

B) A clinical record review revealed that on an identified date on 2017, resident #121's Substitute Decision Maker (SDM) consented to the use of a restraint as a fall prevention strategy. The device was implemented and measures were taken to prevent the resident from removing the device. In 2017, the plan of care to reduce risk of falls included a number of interventions to reduce injury from falls.

In 2017 registered staff #300 completed a personal assistance services device (PASD)/restraints assessment which revealed a plan to continue with the interventions, including a restraint; however, during the same assessment period in 2017, a physiotherapy assessment completed by staff #301 indicated that resident #121 had no restraints in place. Resident #121 was observed on two identified dates in 2018, with the device in place, which they could not remove.

During an interview on January 9, 2018, staff #300 acknowledged that at the time of the 2017 assessment they had copied documentation from a previous assessment including the use of a device which was an error. An interview with staff #301, they also revealed that they made an error when documenting restraint use and confirmed resident did have a restraint in use on the identified assessment date in 2017. The DOC acknowledged that staff assessments with regards to restraint use for resident #121 were not integrated, consistent and nor did they complement each other. [s. 6. (4) (a)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A) The written plan of care for resident #128, revised on a specified date in 2017, revealed that they required specific care from staff to ensure all aspects of toileting task was competed. The plan also indicated that the resident required a specific incontinent product and may use the toilet independently.

Staff #305 stated in an interview that the resident required total assistance of two staff for continence care, as the resident was no longer independent. They also confirmed the resident required a different incontinent product, not specified in the plan of care.

Staff #304 reviewed the written plan of care and confirmed that the resident's plan was not revised when the resident's care needs changed related to toileting.

Resident #128’s, plan of care was not reviewed and revised when their care needs changed. (Inspector #130). [s. 6. (10) (b)]

Issued on this 22nd day of February, 2018

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

Original report signed by the inspector.