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: December 16, 2022	
Inspection Number: 2022-1326-0001	
Inspection Type: Critical Incident System	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: The Village of Wentworth Heights, Hamilton	
Lead Inspector Carla Meyer (740860)	**Inspector Digital Signature** Paola C Meyer Digitally signed by Paola C Meyer Date: 2022.12.19 15:50:56 -05'00'
Additional Inspector(s) Jobby James (694267)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 7th-9th, and 12th, 2022

The following intake(s) were inspected:

- Intake #00014020, [CI# 2841-000015-22] Falls Prevention and Management Program
- The following intake(s) were completed in this inspection: Intake #00001829, CI#2841-000005-22; Intake #00004146, CI# 2841-000012-22/CI: 2841-000011-22; Intake #00004496, CI: 2841-000013-21 were all related to falls.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021 s. 6 (9) 1

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

Rationale and Summary

A resident sustained a fall resulting in an injury and changes to their plan of care.

A Physiotherapy assessment was completed and the resident was assessed to be at high risk of falls, and their plan of care indicated that they were to have a device in place. Inspector reviewed the plan of care with Registered Practical Nurse (RPN) #107 and they informed the inspector that the home tried to obtain the device for the resident but that they currently do not have one due to the device either being broken or not available. The Director of Care (DOC) confirmed that the resident was expected to have this device in place and stated that they were available, and that the home had several in stock.

By not following the resident plan of care, the resident's risk for falls is increased which impacts their safety.

Sources: Resident observations; review of resident's progress notes, and plan of care; Interview with RPN #107, and the DOC.

[740860]

WRITTEN NOTIFICATION: Documentation

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

The licensee failed to ensure that the provision of care as set out in a resident's plan of care was

documented.

Rational and Summary

The resident plan of care indicated that as part of their skin management for prevention of skin breakdown, they were required to be turned and repositioned every two-hours when in bed and wheelchair. The provision of this care to the resident was to be documented every two-hours in Point of Care (POC) under support actions as per schedule. POC documentation record during a 14-day look back revealed that there was several days and scheduled times with missing documentation.

Personal Support Worker (PSW) #108 confirmed that the resident was on an every two-hour turning and repositioning schedule and that this was being provided and that it should be documented on POC right away. This was also confirmed by the DOC, who acknowledged that they did not think the documentation was being done however the care was being provided. They also acknowledged that resident POC documentation for their scheduled every two-hour turning and repositioning was missing documentation on several days and scheduled time.

When the provision of care as set out in the resident plan of care was not documented, the continuity of resident care is impacted.

Sources: Resident's plan of care, and POC Documentation; and Interview with the DOC and PSW #108.

[740860]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee failed to implement any standard or protocol issued by the Director with respect to infection prevention and control.

Rationale and Summary

As per section 10.4 of the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard), the home shall ensure that the hand hygiene program also includes policies

and procedures, as a component of the overall IPAC program, as well as: support for residents to perform hand hygiene prior to receiving meals and snacks, and support for residents who have difficulty completing hand hygiene due to mobility, cognitive or other impairments.

The home's Hand Hygiene policy stated that residents and families were to be encouraged to join in promoting good hand hygiene practices and for opportunities for resident hygiene around meals and snack times was to be offered.

During an observation on December 7th and 8th, 2022 in one Neighbourhood dining room, no hand hygiene assistance were provided or offered by staff to any residents who were entering or assisted to enter the dining room for lunch or prior to meals.

PSW #110 stated that staff were required to assist residents with their hand hygiene and confirmed that staff did not wash or provide hand hygiene to residents as observed by inspectors on December 7th and 8th.

The DOC and Infection Prevention and Control (IPAC) Lead confirmed that the staff were to offer or provide hand hygiene assistance to residents before and after meals.

By not providing or offering hand hygiene assistance, especially to residents who may have difficulty or are not able to perform hand hygiene independently, the risk for transmission of infection is increased.

Sources: Care observations; Interviews with the DOC, IPAC Lead, and PSW #110; and review of the home's policy titled: Hand Hygiene.

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