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

Hamilton District
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Original Public Report

Report Issue Date: November 10, 2023	
Inspection Number: 2023-1326-0003	
Inspection Type: Proactive Compliance Inspection	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: The Village of Wentworth Heights, Hamilton	
Lead Inspector Lesley Edwards (506)	**Inspector Digital Signature** Lesley E Edwards Digitally signed by Lesley E Edwards Date: 2023.11.15 11:31:13 -05'00'
Additional Inspector(s) Nishy Francis (740873)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates:
October 30-31, November 1-3 and 6-8, 2023.

The following intakes were inspected:

- Intake: #00091695 - Proactive Compliance Inspection (PCI).

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices

Pain Management
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 the care set out in the plan of care was provided to a resident as specified in their plan of care.

Rationale and Summary
A resident was required a modified diet texture with thickened fluids at all times according to their plan of care.
On an identified date the resident was observed being given a drink that was not thickened. The registered staff acknowledged that the resident required thickened fluids as per the resident's plan of care.

Failure to provide the resident with the correct fluid consistency could have the potential to cause swallowing complications.

Sources: A resident 's clinical record; resident observations; interview with the registered staff. [506]

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

Rationale and Summary
A resident’s plan of care specified that they were to use an adaptive aide at meals. On an identified date the resident was provided their meal without their required adaptive aide. The PSW acknowledged that they were aware that the resident was to use an adaptive aide at

their meals.

Failure to ensure that the care set out in the plan of care was provided to the resident may have prevented the resident from being independent without the use of the adaptive aide.

Sources: A resident's care plan; observation of the resident, and interview with the PSW. [506]

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

Rationale and Summary
Two PSW's were observed using a specific size of an assistive device when providing care to a resident. Staff acknowledged the resident's plan of care stated the resident was to use a different size of an assistive device.
When a resident's plan of care is not followed, the resident's safety during transfers is at risk which impacts their safety.

Sources: Record review of a resident #001's and interviews with staff.
[740873]

WRITTEN NOTIFICATION: Training

NC #002 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 the persons who received training under subsection (2) received the retraining in the areas mentioned in that section at the intervals as provided for in the regulations.

Rational and Summary
FLTCA s. 82 (1) identified that all staff in the home were to receive training in the areas as required.
FLTCA s. 82 (2) identified that training was required in the areas, including: the home's policy to promote zero tolerance of abuse and neglect of residents and the duty under section 28 to

make mandatory reports.
O. Reg. 246/22 s. 260 (1) identified the retraining was to be completed at annual intervals.

The home provided course completion training records for 2022 for staff training for the prevention of Abuse and Neglect.
Records identified that in 2022 only 66 per cent of the staff completed the required training.

There was a risk that not all staff were familiar with the home's policy to promote zero tolerance of abuse and neglect of residents and the duty under section 28 to make mandatory reports, when they did not receive annual retraining as required.

Sources: Review of staff training records and interview with the Assistant General Manager.
[740873]

WRITTEN NOTIFICATION: General Requirements

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that any actions taken with respect to a resident, under the nursing services program, as required in FLTCA s. 11 (1) were documented.

Rational and Summary
Review of the clinical record for a resident identified they had missed baths for an identified time period.
Interview with the resident identified they received all of their required baths.
Interview with staff acknowledged the baths were not documented.

Sources: Interviews with staff and the resident and clinical record review.
[740873]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #004 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 ensure that the Infection Prevention and Control (IPAC) Standard, April 2022, issued by the Director was complied with.

Rationale and Summary
Specifically, the licensee failed to ensure IPAC Standard Section 9.1 (e) (i) related to routine practices was complied with for at a minimum use of environmental controls including cleaning and administrative controls including but not limited to, comprehensive IPAC policies and procedures.
On an identified date two PSW's were observed not cleaning a mechanical lift after resident use. The home's Assistant General Manager and Senior Director of Nursing acknowledged the shared equipment should be cleaned between resident use.
Review of the home's policy titled lift/sling disinfecting did not provide instructions on cleaning mechanical lifts after resident use. The Senior Director of Nursing acknowledged that the home does not have policies and procedures related to frequency of cleaning mechanical lifts.

Failure to have comprehensive policies and procedures related to the use of environmental controls for cleaning, provided unclear directions to staff and had the potential to increase the risk of spreading an infection.

Sources: Observation of a resident; interview with Assistant General Manager; Senior Director of Nursing and other staff and review of the home's policy titled lift/sling disinfecting.
[740873]

WRITTEN NOTIFICATION: Additional Training-direct care staff

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 2.

The licensee has failed to ensure that all staff who provided direct care to residents received training on skin and wound care in 2022.

Rationale and Summary

Review of the home's training records for direct care staff on skin and wound care identified that the completion rate for 2022 was 56 per cent.
There was risk that all direct care staff may not be familiar with the home's skin and wound care when they did not receive annual training as required.

Sources: Training records and interview with Assistant General Manager.
[506]

WRITTEN NOTIFICATION: Additional Training-direct care staff

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 4.

The licensee has failed to ensure that all staff who provided direct care to residents received training on pain management in 2022.

Rationale and Summary
Review of the home's training records for direct care staff on pain management identified that the completion rate for 2022 was 60 per cent.
There was risk that all direct care staff may not be familiar with the home's pain management program when they did not receive annual training as required.

Sources: Training records and interview with Assistant General Manager.
[506]