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 # / Registre no	Type of Inspection / Genre d'inspection
Oct 25, 2016	2016_240506_0025	024391-16	Resident Quality Inspection

Licensee/Titulaire de permis

CITY OF HAMILTON
77 James Street North, Suite 400 HAMILTON ON L8R 2K3

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

WENTWORTH LODGE
41 SOUTH STREET WEST DUNDAS ON L9H 4C4

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

LESLEY EDWARDS (506), CAROL POLCZ (156), LISA VINK (168)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 18, 19 and 20, 2016.

During this inspection the inspections listed below were conducted concurrently:

Critical Incident Inspections

003012-16 - Fall prevention and safe lifting and transferring.
017885-16 - Abuse and Neglect.
019839-16 - Abuse and Neglect.
029640-16 - Abuse and Neglect.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Nurse Managers, Administrative Assistant, registered nursing staff, Personal Support Workers (PSWs), Resident Assessment Instrument Co-ordinator (RAI), Physiotherapist, Social Worker, Pharmacist, residents and families.

During the course of the inspection the inspectors toured the home, observed the provision of care and services, reviewed relevant records including meeting minutes, policies and procedures and resident health records and conducted interviews.

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

During the course of this inspection, Non-Compliances were issued.

5 WN(s)
4 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 there was a written plan of care for each resident that set out, clear directions to staff and others who provided direct care to the resident.

A review of the plan of care for resident #016 identified they required one person extensive assistance for the entire process of toileting and that they were to be toileted at specified times. Interview with registered staff #110 and #106 identified, that based on the description of the care needs for toileting in the plan of care, staff were required to remain with the resident constantly while on the toilet.
i. A review of the plan of care with nursing staff #129, #128, #102, and #123 identified

that the plan of care directed one staff to assist the resident with the process of toileting; however, did not clearly state that staff must remain in constant attendance while the resident was on the toilet. Interview with registered staff #106 identified that they had held a meeting with nursing staff on an identified date in October 2016, to review the plan of care and clarified that the resident was not to be unattended during toileting. The plan of care did not give clear direction to staff and others who provided care to the resident related to the level of care required during toileting.
ii. A review of the plan of care with staff nursing staff #102 and #118 each identified that the resident was routinely toileted just prior to shift change and that the resident went to bed in the early evening and was later awakened in the evening to be toileted. A review of the plan of care did not provide clear direction regarding the need for the resident to be toileted in the late evening as it only directed toileting to be completed before and after meals and at bedtime. The plan of care did not give clear direction regarding the resident's routine. [s. 6. (1) (c)]

2. 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.

Resident #011 had a medical device in place as confirmed by resident and staff interview and a record review. A review of the Minimum Data Set (MDS) assessment completed on an identified date in May 2016, identified that the resident was occasionally incontinent of bladder, two or more times a week. Registered staff #110 reviewed the supporting documentation, for which the assessment was based on and verified that the resident was not occasionally incontinent of bladder, two or more times a week and that the notation in the MDS was not consistent with the other assessments completed, specifically the Point Of Care (POC) documentation and progress notes. [s. 6. (4) (a)]

3. The licensee failed to ensure that the resident's plan of care was reviewed and revised when the resident's care needs changed.

Resident #031's plan of care confirmed the resident was to use a lift at all times for transfers from bed to their wheelchair. A review of a Critical Incident Report that was submitted to the Director in January 2016, specified the resident sustained an injury while being transferred by two people from their bed to their wheelchair. Interview with the DOC and Nurse Manager #104 on an identified date in October 2016, confirmed the home had a care conference with the family on an identified date in November 2015. It was decided at the care conference the resident will be a two person transfer and will

use the lift only if the resident is assessed as needing it. The DOC and Nurse Manager #104 confirmed the plan of care should have been reviewed and revised as the care set out in the resident's plan changed. [s. 6. (10) (b)]

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 the plan of care sets out clear directions to staff, residents assessments are integrated, consistent and complement each other and the plan of care is reviewed and revised when there are changes, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

The home's resident home area specific "PSW - Shift Roles and Responsibilities, last reviewed September 2015", provided a basic routine for nursing staff to follow during their shift to ensure the completion of resident care and other essential tasks. This routine identified that PSW staff were to "report off pertinent resident information to 3-11 PM staff to transfer care to the oncoming shift."

As identified in the clinical record, an incident report and during an interview with PSW #102, on an identified date in October 2016, the resident was placed on to the toilet by PSW #102, just prior to the end of the shift. The PSW was then called away to respond to the needs of another resident and failed to return to resident #016. The resident was found, at the beginning of the oncoming shift and was assisted off the toilet and provided with care as appropriate. Interview with staff #102 verified they left the resident unattended on the toilet on the identified shift by omission and failed to report this pertinent information to other staff on the unit or to the oncoming shift. The procedure was not complied with. [s. 8. (1) (b)]

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 policies and procedures are followed for shift roles and responsibilities, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used the bed system was evaluated in accordance with evidenced based practices and if there were none, in accordance with prevailing practices, to minimize the risk to the resident.

Health Canada approved two documents identified as "Guidance Documents" and directed that the recommendations in these documents were to be used to assist health care facilities in the assessment of the resident and the resident's bed system when bed rails were used.
These two documents are identified as: "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings", developed by the Hospital Bed Safety Workgroup, dated April 2003, and "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards", based on the US FDA Guidance Document entitled "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment", which was developed by the Hospital Bed Safety Work group and adopted by Health Canada in 2006.

Resident #012 was observed to have two quarter bed rails in the raised position on their bed. A review of the resident's clinical record and interview with the DOC on an identified date in October 2016, confirmed that the resident used both rails as a positioning device. The DOC confirmed the resident had not been assessed for the use of the bed rails. [s. 15. (1) (a)]

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 where bed rails were used the bed system was evaluated in accordance with evidenced based practices and if there were none, in accordance with prevailing practices, to minimize the risk to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

On an identified date in February 2016, resident #014's Treatment Administration Record (TAR) identified the resident had a new pressure area on an identified area on their body. A review of the clinical record and interview with Nurse Manager #109 confirmed that the resident was not assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound until March 31, 2016. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was not reassessed at least weekly by a member of registered nursing staff.

Resident #014 had an identified stage two pressure area on a specified area of their body on an identified date in September 2016. Documentation in the progress notes identified the pressure ulcer as worsening and had been staged as a stage three pressure ulcer on an identified date in October 2016. A review of the clinical record confirmed that the resident had not received a weekly skin assessment since an identified date in September 2016. Nurse Manager #109 confirmed that the pressure ulcer was not reassessed at least weekly by the registered nursing staff. [s. 50. (2) (b) (iv)]

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 residents who exhibit altered skin integrity receive a skin assessment using a clinically appropriate assessment and residents who with altered skin integrity are reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the long term care home was a safe and secure environment for its residents.

During the initial tour of the home on an identified date in October 2016, the door to the infection control office on Rose Court home area was found to be open and unlocked. An open box containing sealed packages of needles (without syringes) were found on the shelf. PSW staff #116 reported that the door was often open so the cat could go in and out. The DOC reported on an identified date in October 2016 that the room was to remain locked at all times. [s. 5.]

Issued on this 26th day of October, 2016

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

Original report signed by the inspector.