Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 4, 2019	2019_556168_0024	019691-19, 020054-19	Critical Incident System

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

LISA VINK (168)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 18, 19 and 20, 2019 (onsite) and telephone interviews conducted on December 2, 2019.

This Critical Incident System (CIS) inspection was conducted related to log numbers:
019691-19 - related to falls prevention and management; and
020054-19 - related to plan of care.

During the course of the inspection, the inspector(s) spoke with the acting Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), the Resident Assessment Instrument Coordinator, the Physiotherapy Assistant (PTA), the Physiotherapist (PT), the Kinesiologist, Personal Support Workers (PSW), staff from StL Diagnostic Imaging and (HME) Home Medical Equipment and residents.

During the course of the inspection, the inspector observed the provision of care and services, reviewed relevant records including but not limited to: clinical health records, policies and procedures, incident reports, meeting minutes, and schedules.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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	Légende 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. (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 resident #011 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 and they were provided palliative care measures.

i. According to the clinical record resident #011 demonstrated symptoms of pain on an identified date in 2019. The following day they were assessed and as a result their program of physiotherapy was put on hold.
Interview with the physiotherapist identified that the resident did not return to the program prior to their discharge from the home.
A review of the plan of care in place at the time of discharge did not include that the resident was currently on hold for the physiotherapy program.
The plan noted that the resident received therapy which was confirmed by the physiotherapist following a review of the clinical record.
ii. According to the clinical record resident #011 sustained an injury of unknown origin, which was diagnosed on a specified date in 2019.
The decision maker, for the resident, requested that the resident remain at the home and be provided comfort measures.
The resident was bed fast since the time of the diagnosis.
A physician's note identified that the resident was palliative, followed by additional palliative orders two days later for specific interventions, which continued until their discharge.
A review of the plan of care, in place at the time of discharge, did not include that the resident was palliative nor the use of the intervention.
The plan included not the put the resident to bed early, noted their preference to stay up, as well as their desired time to get up in the morning and go to bed in the evening, as confirmed with RPN #102, following a review of the plan of care.

The plan of care was not updated with changes in the resident's care needs. [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 that residents are 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 change, 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 the policies included in the required program of Nursing Services were complied with.

In accordance with Long-Term Care Homes Act, 2007 (LTCHA) section (s.) 8 the licensee was required to have an organized program of nursing services to meet the assessed needs of residents and s. 12, which required the licensee to ensure that there was an organized program of medical services for the home.

Specifically, the licensee's policy in the Nursing Manual titled Radiology, tab 03-05, was not complied with.
This policy identified that "the attending physician will write an order for all x-rays and the team leader will complete a requisition according to the physician's order".

The home had an arrangement with StL Diagnostic Imaging to provide mobile x-ray

services to residents of the home.
As per RN #109 prior to the completion of any x-ray, staff were to complete the x-ray requisition form, in full, including the reason for the examination (relevant history) as well as who was the requisitioning medical practitioner / registered nurse in the extended class and their Ontario Health Insurance Plan (OHIP) number.
Telephone discussion with staff at StL Diagnostic Imaging confirmed that only specified medical professionals were able to order an x-ray. As detailed on their website these individuals included: physicians, dentists, chiropractors, designated chiropodists or osteopaths.

i. A review of the clinical record for resident #014 identified that they displayed symptoms starting on an identified date in 2019, which continued for a period of time.
A progress note, dated seven days later, by RPN #113, included information that "x-ray requisition sent".
The clinical record included a StL Diagnostic Imaging Report, an x-ray report, dated the day after the progress note, which confirmed the suspected condition, which was confirmed by RPN #113.
A review of the physician's orders, during the identified time period, did not include an order for an x-ray, which was confirmed by RPN #113, following a review of the clinical record.
Interview with RPN #113 confirmed that they wrote the note and initiated an x-ray requisition; however, this intervention was completed based on assessments completed by nursing staff.

ii. A review of the clinical record for resident #011 included a progress note by RN #112, which identified that the resident presented with an injury on an identified date in 2019. The note queried possible causes for the injury, an assessment, treatment, that an x-ray requisition was faxed to StL for further assessment and that the resident was added to the physician's list for assessment.
An entry was created in the physician's order the same day, for an x-ray for further assessment, which was signed by the physician.
The clinical record included an x-ray report, for the area of suspected injury.
Interview with the DOC identified that they previously spoke with RN #112 regarding the injury and actions taken as a result, and confirmed that the RN submitted the requisition for x-ray prior to receipt of an order from the physician, at which time the DOC communicated the expectations that the physician be notified and orders received for x-rays.
Interview with RN #112 confirmed that they initiated the x-ray without an order from the

physician, based on their physical assessment.

Interviews with RN #112 and #109 indicated that they had previously been told by the physician that they, as registered staff, may initiate an x-ray, if they felt it was warranted, based on their assessment findings.

Interview with the DOC confirmed that the home did not have any written direction for registered staff to initiate an x-ray without a specific and individualized physician's order and their plan to address the concern at the Registered Staff meeting scheduled for December 2019.

The policy 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 that where the Act or Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy that the licensee is required to ensure that the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that that any actions taken with respect to a resident under the maintenance services program, including assessments and interventions were documented.

Long-Term Care Homes Act, 2007 (LTCHA) section (s.) 15 required the licensee to have an organized program of maintenance services in the home.

Resident #011 utilized a mobility device according to the Kinesiologist.
A review of the progress notes, of an identified date in 2019, by RPN #108, noted that the resident sustained a fall while utilizing the device and included the intervention of a referral to the Kinesiologist, to check the device for proper functioning.
Interview with RPN #108 identified that they communicated this referral verbally to the Kinesiologist in a meeting the same day and recalled the Kinesiologist reporting to them that the device was assessed and in a good state of repair.
Interview with the Kinesiologist identified that they recalled the incident, the referral and assessing the device; however, confirmed that there was no written documentation taken regarding their assessment or their interventions.

The assessment of the chair nor interventions were not documented. [s. 30. (2)]

Issued on this 4th day of December, 2019

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

Original report signed by the inspector.