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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Public Report

Report Issue Date: December 11, 2024
Inspection Number: 2024-1326-0002
Inspection Type: Critical Incident
Licensee: Schlegel Villages Inc.
Long Term Care Home and City: The Village of Wentworth Heights, Hamilton

INSPECTION SUMMARY

The inspection occurred on-site on the following dates: November 25-29 and December 2-5, 2024.

The following intakes were inspected:

- Intake #00118299/ Critical Incident (CI) #2841-000010-24, Intake #00131953/ CI #2841-000024-24 & Intake #00132232/ CI #2841-000025-24 were related to prevention of abuse and neglect
- Intake #00121970/ CI #2841-000017-24 was related to outbreak management
- Intake #00123979/ CI #2841-000019-24 was related to fall prevention and management

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee failed to uphold a resident's right to have their personal health information (PHI) within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

Rationale and Summary
Nursing management sent a staffing agency agency documentation by email containing a resident's name and specified PHI without safeguards in place as required by their privacy policy.

Failure to ensure the required safeguards were in place when sending personal information and PHI by email posed a risk of unauthorized access and a breach of the resident's privacy.

Sources: Staff email records, privacy policy, interview with nursing management.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
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;

The licensee failed to ensure that the written plan of care for a resident set out the planned care related to a behavioural monitoring intervention.

Rationale and Summary
A resident was to have a specified behavioural monitoring intervention in place at the time of two reported incidents of abuse. Nursing management acknowledged that planned care related to this intervention was not set out in the plan of care

Failure for the resident's written plan of care to set out planned care related to the specified behavioural monitoring intervention may have contributed to care not being provided to the resident as required.

Sources: Resident clinical record, CI 2841-000024-24 and 2841-000025-24, staff email records, interviews with nursing management and staff.

WRITTEN NOTIFICATION: Staff and Others to Be Kept Aware

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)

Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee failed to ensure that staff who provided direct care to a resident had convenient and immediate access to their plan of care.

Rationale and Summary
A resident had a one to one (1:1) staff intervention in place to support monitoring of the resident. The 1:1 staff also provided direct care to the resident; however, did not have a log-in to access Point-of-Care (POC). The resident's complete plan of care was accessible to personal support workers (PSWs) through POC. Staff providing 1:1 to the resident at the time of the inspection were not familiar with the specific care needs of the resident.

When 1:1 staff did not have convenient or immediate access to the resident's complete plan of care, there was a risk of care not being provided to the resident as required.

Sources: Resident clinical record, staff email records, documentation policy, interviews with nursing management and staff.

WRITTEN NOTIFICATION: Duty to Protect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to protect two residents from physical abuse by another resident.

Section two of the Ontario Regulation (O. Reg.) 246/22 defined resident to resident physical abuse as the use of physical force by a resident that caused physical injury to another resident.

Rationale and Summary
A) A resident pushed a co-resident, resulting in the resident falling to the floor and sustaining multiple areas of skin impairment.

Sources: Resident clinical records, interview with nursing management.

B) A resident tripped over another resident when they were walking past them and slapped the resident, resulting in an injury.

Nursing management acknowledged that both incidents met the definition of physical abuse. Failure to protect both residents from physical abuse by another resident led to actual harm of the residents.

Sources: Resident clinical records, interviews with nursing management and staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the

information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee failed to immediately report to the Director, the improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

Rationale and Summary
A resident fell and staff manually lifted the resident off the floor before they were assessed by a nurse. The home's policies indicated the resident was to be transferred from the floor using a mechanical lift, only after being assessed by a registered nursing team member. The resident was transferred to hospital and diagnosed with a fracture. Staff acknowledged that the resident received improper care and nursing management confirmed this was not immediately reported to the Director.

Sources: Resident clinical record, investigation notes, CI 2841-000019-24, fall prevention and management program, mechanical lift policy, interviews with nursing management and staff.

WRITTEN NOTIFICATION: Policies and Records

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 11 (1) (b)
Policies, etc., to be followed, and records
s. 11 (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, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,

(b) is complied with.

The licensee failed to comply with their complaints policy.

Rationale and Summary
The home's complaint policy required staff to maintain a record of all complaints and forward completed response forms to specified management team members for review and record keeping. A complaint was made related to the care of a resident. There was no complaint response form related to the complaint in the home's complaint binder.

Sources: Complaints procedure, complaint binder, interviews with nursing management and staff.

WRITTEN NOTIFICATION: General Requirements

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (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.

The licensee failed to ensure that any actions taken with respect to multiple residents, including assessments, interventions and the residents' responses to interventions were documented.

Rationale and Summary
A) A resident had a 1:1 staff intervention in place to support monitoring of the resident. The staff also provided direct care to the resident; however, did not have a

log-in to access the resident's plan of care through POC. They were expected to report care activities to other staff to document on their behalf.

When staff who provided care was unable to document the care provided, resident contact with health care personnel was not accurately documented and staff accountability to document care provided was reduced.

Sources: Documentation policy, interviews with nursing management and staff.

B) A resident was pushed by a co-resident and fell, sustaining multiple areas of altered skin integrity. According to documentation, the resident was assessed as experiencing pain at the time of the initial nursing assessment. Staff indicated the resident's pain subsided after initial skin and wound intervention; however, the reduction in pain was not documented.

When staff did not document resolution of the resident's pain, there was a gap in the resident's pain management records.

Sources: Resident clinical record and interview with staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that staff used safe transferring and positioning

devices or techniques when assisting residents.

Rationale and Summary
A resident fell and staff manually lifted them off of the floor. The home's policies directed staff to transfer a resident from the floor using a mechanical lift. Following the fall, the resident was transferred to hospital and diagnosed with a fracture.

Transferring the resident manually after the fall put the resident at risk of injury.

Sources: Resident clinical record, investigation notes, CI 2841-000019-24, fall prevention and management program, mechanical lift policy and interviews with staff.

WRITTEN NOTIFICATION: Required Programs

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee failed to ensure that the home's fall prevention and management program was implemented.

Rationale and Summary
A resident fell and staff manually lifted the resident off the floor before they were assessed by a nurse. The home's fall program indicated the resident was to be transferred from the floor using a mechanical lift, only after being cleared by a

registered team member to do so.

By not following the policy, the resident was at risk of injury.

Sources: Resident clinical record, investigation notes, CI 2841-000019-24, fall prevention and management program and interviews with staff.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (3) (a)
Responsive behaviours
s. 58 (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices;

The licensee failed to ensure that the matters referred to in subsection (1) were implemented for a resident. Specifically, written approaches to care, including assessments and reassessments of the resident's responsive behaviours, were not implemented.

Rationale and Summary
A resident had a history of demonstrating responsive behaviours toward co-residents and staff. The home's responsive behaviour program directed staff to implement multiple assessment tools after an incident involving a resident's behavioural expression to evaluate the context and risk of the behaviour. Nursing management acknowledged that the required assessments were not implemented when the resident was involved in multiple incidents, which led to actual harm to co-residents.

Failure to ensure the required assessments were implemented may have led to gaps in the home's management of the resident's behaviours.

Sources: Resident clinical record, CI 2841-000024-24 and 2841-000025-24, responsive behaviours program and assessment tools, interviews with nursing management and staff.

WRITTEN NOTIFICATION: Reports Re Critical Incidents

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee failed to ensure the Director was immediately informed of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Rationale and Summary
An outbreak was declared on a specified date and the Director was informed the following day.

Sources: CI 2841-000017-24, staff email records and interview with nursing management.