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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Dec 5, 2014	2014_210169_0024	H-001511-14	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

YVONNE WALTON (169), KELLY HAYES (583), THERESA MCMILLAN (526)

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): November 12, 13, 14, 17, 18, 19 2014

The following inspections were completed during this inspection and the findings are included in this report. Complaint #H-00860-14 and Critical incident #H-00424-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing, Nurse Managers, Administrative Assistant, Director of food Service, Dietitian, physicians, Social Worker, Infection Control Practitioner, Nursing staff, housekeeping staff, dietary staff, Residents and families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

9 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her 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 his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident was treated in a way that fully recognized the residents individuality.

During lunch service on November 18, 2014 on Maple Unit it was observed by the inspector that none of the residents received knives as part of their cutlery. Dietary aides and nursing staff confirmed knives were not offered to any resident on this unit.

During lunch service on November 18, 2014 on Maple Unit it was observed all residents

received a meal with chopped meat.
A review of the diet list showed that nineteen residents on Maple home area were assessed to be on a regular diet, not with chopped meat. In an interview with the Food Service Supervisor and Registered Dietitian (RD) on November 18, 2014 it was confirmed that regular texture food that could not be eaten with your hands was chopped for all residents on the Maple unit. It was confirmed with the RD that the nineteen residents who were assessed as being able to eat regular texture were receiving a chopped diet.

During lunch service on November 18, 2014 on Maple Unit it was observed that none of the residents received side plates and when crackers were served, they were placed by staff onto the bare table. Staff identified some residents have behaviours where dishes get knocked onto the floor and can break, therefore they don't provide side plates.

During lunch service on November 18, 2014 on Maple Unit it was observed that none of the residents received napkins. This was confirmed by the dietary staff.

In an interview with the DOC is was verified that some residents whom it was appropriate for were not receiving knives, regular texture diet, side dishes and napkins. It was confirmed that residents were not treated in a way that fully recognized each residents individuality. [s. 3. (1) 1.]

2. The licensee has failed to ensure that the right of every resident to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act was fully respected and promoted.

On November 17, 2014 at approximately 1230 hours, a registered staff was observed to discard used resident medication packets into the garbage without ensuring that the residents' personal health information located on the packets was removed. The Director of Care (DOC) confirmed that the home's practise was to dispose of the used medication packets into the garbage without first removing residents' personal health information. The DOC indicated that the current practise did not fully respect or promote the confidentiality of residents' personal health information. [s. 3. (1) 11. 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 that ensures every resident is treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the residents dignity and ensures all residents have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, to be implemented voluntarily.

WN #2: 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 has failed to ensure that the written plan of care set out clear directions to staff and others who provided direct care to the resident.

Resident #016 Resident Assessment Instrument (RAI) Minimum Data Set (MDS) completed on November 5, 2014 indicated that the resident did not use bed rails for bed mobility or transfers and that the resident did not use full or other types of bed rails. On November 17, 2014 at approximately 1500 hours the resident was observed laying in bed with two, one half bed rails in the raised position. The document the home referred to as resident #016 care plan completed November 12, 2014 did not direct staff regarding the use of bed rails for resident #016. A personal support worker (PSW) staff person interviewed on November 17, 2014 stated that resident #016 used bed rails for mobility and that the rails should be up at all times. This was not included in the plan of care.

The DOC confirmed that the resident's RAI MDS and care plan as noted above did not include that the resident used bed rails and did not provide clear direction to staff regarding the use of bed rails for resident #016. [s. 6. (1) (c)]

2. On November 17, 2014 resident #038 was observed in bed with two quarter middle rails in the up position. A review of the plan of care showed that resident #038 bed rails were not identified in the plan of care. In an interview with registered staff on November 17, 2014 it was shared that two quarter middle rails were used for resident #038 when they were in bed. Registered staff confirmed the bed rails were not documented in the plan of care. In an interview with the Director of Care on November 17, 2014 it was confirmed that the plan of care did not provide clear direction for resident #038's related to bed rail use. [s. 6. (1) (c)]

3. Resident #017 RAI MDS completed on August 27, 2014 indicated that the resident used bed rails for bed mobility and transfer and that the resident used other types of bed rails. On November 17, 18, and 19, 2014 the resident was observed laying in bed with two, one half bed rails in the raised position. The document the home referred to as resident #017 care plan completed September 19, 2014 did not direct staff regarding the use of bed rails. A Registered Nurse interviewed on November 19, 2014 stated that resident #017 used bed rails for mobility and confirmed that the use of bed rails had not been included in the resident's care plan, to provide clear direction to staff. [s. 6. (1) (c)]

4. The licensee has failed to ensure that staff and others involved in the different aspects

of care collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

In October, 2014, resident #016 was found by staff sitting on the floor twice. The resident's (RAI MDS) completed on November 5, 2014 indicated that the resident had not fallen in the previous 30 days. Registered staff confirmed that resident #016 assessments of falls were not integrated, consistent or complemented each other. Interview on November 17, 2014 with the RAI Coordinator confirmed this lack of integration. [s. 6. (4) (a)]

5. Resident #016 RAI MDS completed on November 5, 2014 indicated that the resident was occasionally incontinent (was noted to be incontinent two or more times per week but not daily) during the 14 days prior to the assessment. Review of the resident's health record indicated that the resident was incontinent or both continent and incontinent every day. During interview on November 17, 2014, the DOC confirmed that resident #016 was not occasionally incontinent as noted in the RAI MDS assessment of November 5, 2014. The DOC also noted that the RAI MDS assessment was not consistent with the resident's continence flow sheet assessments. [s. 6. (4) (a)]

6. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs change.

Resident #017's most recent RAI MDS assessment was completed on August 27, 2014. According to the Registered Nurse (RN), resident #017 had a significant change in condition since August 2014. The RN stated that the resident had exhibited a significant change in condition since November 10, 2014. The document the home referred to as the "care plan" completed on September 19, 2014 was the most recent care plan.

The RN confirmed that resident #017 had not been reassessed and that the plan of care had not been updated when the resident's care need changed regarding the resident's lethargy, changes in mobility, changes in nutrition patterns, changes in continence, and changes in range of motion. [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 that ensures there is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident. Also to 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 (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. Also ensures that every 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; (b) the resident's care needs change or care set out in the plan is no longer necessary; or (c) care set out in the plan has not been effective., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that two bath chairs were maintained in a safe condition and good state of repair.
On November 18, 2014 the shower chair ML6 was observed to have an approximately four inch crack in the gray pad. On November 18, 2014 the Arjo tub chair was observed with the blue finish worn off the entire chair. Both chairs would result in difficulty cleaning and also would be rough against resident skin. The nursing staff confirmed the chairs were in poor condition. [s. 15. (2) (c)]

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 that ensures (a) the home, furnishings and equipment are kept clean and sanitary; (b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and (c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair., to be implemented voluntarily.

WN #4: 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 has failed to ensure that when bed rails were used residents were assessed in accordance with prevailing practises to minimize risk to the residents.

On November 17, 2014 resident #038 was observed in bed with two quarter middle rails in the up position. A review of the plan of care showed that resident #038 was not assessed for bed rails. In an interview with registered staff on November 17, 2014 it was shared that two quarter middle rails were used for resident #038 when they were in bed and that the bed rails were not documented in the plan of care. In an interview with the Director of Care on November 17, 2014 it was confirmed that resident #038 had not received an assessment for the use of their bed rails. [s. 15. (1) (a)]

2. Resident #016's RAI MDS completed on November 5, 2014 indicated that the resident did not use bed rails for bed mobility or transfer and that the resident did not use full or other types of bed rails. On November 17, 2014 at approximately 1500 hours the resident was observed laying in bed with two, one half bed rails in the raised position. Review of the resident's health record indicated that an assessment of resident #016 in relation to their bed system had not been conducted. The DOC indicated that the home had not assessed residents in relation to their respective bed systems and confirmed that resident #016 had not been assessed. [s. 15. (1) (a)]

3. Resident #017's RAI MDS completed on August 27, 2014 indicated that the resident used bed rails for bed mobility and transfer and that the resident used other types of bed rails. On November 17, 18, and 19, 2014 the resident was observed laying in bed with two, one half bed rails in the raised position. Review of the resident's health record indicated that an assessment of resident #016 in relation to their bed system had not been conducted. The DOC indicated that the home had not assessed residents in relation to their respective bed systems and confirmed that resident #017 had not been assessed. [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 that ensures that where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practises and, if there are none, in accordance with prevailing practises, to minimize risk to the resident; (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and (c) other safety issues related to the use of bed rails are addressed, including height and latch reliability., to be implemented voluntarily.

WN #5: 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 where the Act or 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, that the licensee ensured that the plan, policy, protocol, procedure, strategy or system was in compliance with all applicable requirements under the Act.

A review of the Quality Management policy AM-03-01-03 "How are we doing policy Compliment/Opportunities for Improvement/Theft/Concern" last revised September 10, 2013 was completed. The policy directed the Administrator to respond to the Residents' Council and Family Council concerns, suggestions and /or opportunities for improvement in writing upon the receipt of the meeting minutes within 21 days. In an interview with the Administrator on November 19, 2014 it was confirmed that the policy was not in compliance with the requirement of the Act for the licensee to respond to Residents' and Family Council in writing within 10 days of receiving advice. [s. 8. (1) (a)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The home's Medication System Policy 3-6 for The Medication Pass stated "Empty strip pouches can be destroyed with water to remove information and placed into the garbage or shredded (PIPEDA)".

On November 18, 2014 a registered staff was observed to dispose of empty medication strip pouches with resident personal health information on the pouch directly into the garbage on the medication cart. The registered staff person stated that disposing of the used strip pouches in this way was the home's usual practise. On November 19, 2014, the DOC reviewed the home's policy 3-6 and stated that the home had not followed its policy regarding the safe disposal of personal health information located on the medication strip pouches. [s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were offered preventive dental services, subject to payment being authorized by the resident/SDM if payment required.

In an interview with resident #019 on November 17, 2014 it was shared that they had mouth pain. A review of the plan of care showed that resident #019 was not seen by the dental services in the home when they came to visit resulting in the resident being missed and continued to have mouth pain.34. (1) (c)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that a response was provided in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Residents' Council meeting minutes and response forms were reviewed from January to September, 2014. It was identified in the July, 2014 minutes that two concerns were brought forward at residents council and no response forms were completed. In an interview with the Administrator and the Residents' Council assistant it was verified that a response was not provided in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations. [s. 57. (2)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations. Review of minutes for Family Council meetings that took place during 2014 indicated that concerns and recommendations made by Family Council during the meetings had not been responded to in writing within 10 days by the Administrator. The Family Council representative confirmed this during interview on November 14, 2014. The Administrator confirmed during interview on November 18, 2014 that he had not responded in writing within 10 days to concerns and recommendations made during Family Council meetings held during 2014. [s. 60. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.
On November 12, 2014 the shower room in a home area was observed and had a used, un-labelled deoderant stick on the shelf and another home areas were observed and had a used and un-labelled comb on the shelf. The nursing staff confirmed they should not be in the shower rooms. On November 18, 2014 the shower room on another home area was observed and had two nail clippers in the care caddie used by the nursing staff. Both nail clippers had soiled nail clippings stuck in them were unlabelled. The nursing staff stated residents should have their own nail clippers in their rooms. The infection prevention and control practitioner confirmed the home was implementing a process to ensure nail clippers were not shared between residents.

Crackers were served on the table at lunch meal on November 18 in Maple home area. No side plates were used and the crackers were placed directly on the table. The dining area is also used as a lounge and is open to resident use between meals. There are several residents with behaviours such as spitting resulting in a potential infection control concern. Staff were not observed washing tables before the meal service nor do they set the tables until residents arrive to the dining area. [s. 229. (4)]

Issued on this 5th day of December, 2014

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

Original report signed by the inspector.