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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Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: February 22, 2023

Inspection Number: 2023-1593-0002

Inspection Type:
Complaint
Critical Incident System

Licensee: City of Hamilton

Long Term Care Home and City: Wentworth Lodge, Dundas

Lead Inspector	**Inspector Digital Signature**
Stephanie Smith (740738)	Stephanie D Smith Digitally signed by Stephanie D Smith Date: 2023.02.27 08:24:38 -05'00'

Additional Inspector(s)
Barbara Grohmann (720920)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 30-31, February 2-3, and 6-8, 2023

The following intake(s) were inspected:
- Intake: #00003133- Alleged neglect of resident
- Intake: #00016767- Fall of resident
- Intake: #00007777- Complaint related to care concerns

The following intake(s) were completed in this inspection:
Intake #00003557, Intake #00006612, Intake #00009081, were related to falls prevention and management.

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

Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration

Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that the plan of care was revised when a resident's care needs changed.

Rationale and Summary
A Resident was observed on a specified date in January 2023, to have a chair alarm present as a falls prevention intervention.

A clinical record review revealed that the application of a chair alarm was not in the resident's plan of care. On a specified date in February 2023, the resident's plan of care was updated to include application of a chair alarm as a falls prevention intervention. A Registered Practical Nurse (RPN) verified that the plan of care had been updated that day to include the application of a chair alarm.

Sources: Resident's plan of care, observations, and interview with RPN. [740738]

Date Remedy Implemented: February 2, 2023

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (7)

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

specified in the plan related to skin surveillance.

Rationale and Summary
The home's Skin and Wound Care Program stated that Personal Support Workers (PSWs) would conduct skin surveillance and document in an electronic medical record (EMR) task twice weekly during bathing and as needed. A resident's care plan stated that skin surveillance was to be done twice a week, on every bath.

EMR bathing records were reviewed for the resident from December 2021 to May 2022 and identified the following:
- four baths were provided in December 2021, no skin surveillance was completed for those baths.
- six baths were provided in January 2022, no skin surveillance was completed for those baths.

Nurse Manager and Skin and Wound Lead acknowledged that skin surveillance was done by PSWs when the residents were bathed and documented in an EMR.

Failure to complete skin surveillance as per the resident's plan of care may have resulted in missed incidents of altered skin integrity.

Sources: Resident's clinical records, Skin & Wound Care Program (NM 03-08-14, May 20, 2021), interviews with Nurse Manager and other staff. [720920]

B. The licensee has failed to ensure that the care set out in a resident's plan of care was provided as specified in the plan related to continence product changes.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee’s non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 6 (7) of LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 6 (7) of FLTCA.

Rationale and Summary
A resident's substitute decision maker (SDM) contacted the home in March 2022, regarding concerns that the resident was not being changed frequently enough. A Registered Nurse (RN) spoke with the SDM and they agreed to add an additional change of continence product every day between specified hours. The resident's kardex and tasks were updated with that information.

A review of EMR documentation after that date in March 2022, indicated that the resident was not

changed as per the updated plan of care, three times in March, nine times in April, and three times in May 2022.

A PSW stated they were unaware that the resident was to be changed every day between the specified hours. The Director of Care (DOC) acknowledged that the staff were expected to follow the resident's plan of care, which included their Kardex.

Failure to provide care as per the plan of care may have resulted in the resident not receiving care as per their needs.

Sources: Resident's clinical records, and interviews with DOC and other staff. [720920]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with s. 30 (2) of O. Reg. 79/10 under the Long-Term Care Homes Act, 2007 and s. 34 (2) of O. Reg. 246/22 under the FLTCA.

The licensee has failed to ensure that any actions taken with respect to a resident under the nursing and personal support services program, including interventions, were documented for a resident related to continence product changes.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 30 (2) of O. Reg. 79/10 under the LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 34 (2) of O. Reg. 246/22 under the FLTCA.

Rationale and Summary
A resident's SDM voiced concerns that the resident's continence products were not changed frequently enough.

EMR documentation was reviewed from December 2021 to May 2022, for the resident.

The records identified brief changes during night shift were not documented:
- twice in December 2021
- seven times in January 2022

- six times in February 2022
- six times in March 2022
- six times in April 2022
- nine times in May 2022

A PSW stated that they are required to use an EMR system to document continence changes. The DOC acknowledged that staff were expected to complete their documentation by the end of their shift.

Failure to document tasks as required may have resulted in inconsistent care.

Sources: Resident's clinical records, interviews with DOC and other staff. [720920]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (10) (b)

The licensee has failed to revise a resident's plan of care when their SDM requested meal trays to be left in the resident's room.

Rationale and Summary
A resident's SDM requested that a tray be left in the resident's room. A progress note indicated that the care plan would be updated directing staff to leave a meal tray in the resident's room.

The resident's care plan and kardex indicated that they were to be provided a tray and that the tray was to be removed after the meal or an hour.

Failure to revise the plan of care had the potential for the resident not to receive care in accordance with their needs.

Sources: Resident's clinical records, interviews with DOC and other staff. [720920]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #005 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 for Long-Term Care Homes, dated April 2022, was implemented.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, stated under section 9.1, that Routine Precautions were to be followed in the IPAC program which included (d) the proper use of Personal Protective Equipment (PPE) including the appropriate selection, application, removal, and disposal.

A Screener was observed performing a COVID-19 rapid antigen test (RAT) on a visitor while wearing a gown, gloves, and a medical mask; no eye protection was present. After the test, the Screener continued to tend to other tasks while wearing the same pair of gloves.

The Screener stated they were not required to wear eye protection when performing a COVID-19 RAT. The IPAC Lead acknowledged that when performing a COVID-19 RAT on another person, the screener should be wearing eye protection and that gloves are to be used for one task only.

Failure to properly use PPE led to increased risk for transmission of infection.

Sources: Observations, interview with IPAC Lead, IPAC Standard for Long-Term Care Homes, April 2022. [740738]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 24 (1) 2.

The licensee has failed to ensure that the Director was immediately informed when a complaint, received by the home, alleged neglect.

Rationale and Summary
A critical incident (CI) report submitted to the Director indicated that home received a complaint from a resident's SDM on a specified date in March 2022.

The CI was first submitted to the Director 10 days later.

Sources: CI, complaint email (March 2022); and interview with the DOC. [720920]