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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Original Public Report

Report Issue Date: March 27, 2024
Inspection Number: 2024-1593-0001
Inspection Type: Proactive Compliance Inspection
Licensee: City of Hamilton
Long Term Care Home and City: Wentworth Lodge, Dundas

Lead Inspector	**Inspector Digital Signature**
Lesley Edwards (506)	Lesley E Edwards Digitally signed by Lesley E Edwards Date: 2024.03.28 11:00:31 -04'00'

Additional Inspector(s)
Lisa Vink (168)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: February 27, March 13, 14, 15, 18, 19, 21, 22 and 25, 2024
The inspection occurred offsite on the following dates: March 15, 2024

The following intake inspected:

- Intake: #00109813 - Proactive Compliance Inspection (PCI).

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management

Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
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)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
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,
(c) clear directions to staff and others who provide direct care to the resident.

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary
A logo above a resident's bed noted the use of a specific lift.
The care plan identified the lift, with a specific intervention in place as well as the use of two different sized slings. Review of the care plan in March 2024, no longer directed staff of the specific intervention and identified the use of the correct sling size as acknowledged by a Registered Practical Nurse (RPN).

Sources: Plan of care for a resident; interview with Personal Support Worker (PSW) and other staff.
[168]

Date Remedy Implemented: March 19, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary.

The licensee has failed to ensure that a resident's plan of care was revised when care set out in the plan was no longer necessary.

Rationale and Summary
The plan of care for a resident indicated the resident was to use adaptive aides with their meals. Observation of the resident during meal service identified they were not using the adaptive aide. The RPN indicated the resident did not need these interventions at this time.

In March 2024, the plan of care was revised and removed the interventions, which were no longer necessary.

Sources: Observation of a resident; review of the clinical health records; interview with RPN; Registered Dietitian and other staff.
[506]

Date Remedy Implemented: March 13, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 18 (1) (a)
Bed rails
s. 18 (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and the resident's 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;

The licensee has failed to ensure that where bed rails were used for a resident they were assessed to minimize risk to the resident.

Rationale and Summary
A resident had two raised assist rails on their bed, the resident and staff confirmed the use of the rails. The plan of care noted the use of bed rails to support the resident and the most recent assessment for bed rails did not include their use.
In March 2024, the resident was reassessed and identified a need for bed rails.

Sources: Observations and interview with a resident; review of plan of care and bed rail assessments; interviews with RPN and other staff.

[168]

Date Remedy Implemented: March 20, 2024

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
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 has failed to ensure that any actions taken with respect to a resident under the required program of nursing and personal support services, as set out in section 11 of FLTCA, including interventions and the resident's responses to interventions were documented.

Rationale and Summary
A resident identified they were consistently bathed twice a week and flow sheets identified that bathing was documented as completed on only two occasions during a two week period.
A PSW acknowledged twice a week bathing and was able to recall bathing the resident during the identified time frame; however, in error, it was not documented. In March 2024, the PSW documented the bathing as completed in the presence of the Inspector.

Sources: Review of flow sheets; care plan and progress notes of a resident and interview with PSW.
[168]

Date Remedy Implemented: March 19, 2024

NC #005 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. ii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
ii. the results of the survey taken during the fiscal year under section 43 of the Act, and

The licensee has failed to ensure that their continuous quality improvement report, published on their website included a written record of the results of the survey taken during the fiscal year under section 43 of the Act.

Rationale and Summary
A review of Wentworth Lodge's website included their March 30, 2023, Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario.
The report did not include a written record of the results of the survey taken during the fiscal year under section 43 of the Act.
The Manager of Quality Improvement and Privacy acknowledged that the information as required was not included in the published continuous quality improvement report, nor was the information located elsewhere on the website.
The following day the website was updated and included the required information.

Sources: Review of the Wentworth Lodge's website including the narrative report and interview with the Manager of Quality Improvement and Privacy.
[506]

Date Remedy Implemented: March 14, 2024

NC #006 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. iii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that their continuous quality improvement report, published on their website included how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, and members of the staff of the home.

Rationale and Summary
A review of Wentworth Lodge's website included their March 30, 2023, QIP Narrative for Health Care Organizations in Ontario.
The report did not include how, the dates when and the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, and members of the staff of the home.
The Manager of Quality Improvement and Privacy acknowledged that the information as required was not included in the published continuous quality improvement report, nor was the information located elsewhere on the website.
The following day the website was updated and included the required information.

Sources: Review of the Wentworth Lodge's website including the narrative report and interview with the Manager of Quality Improvement and Privacy.
[506]

Date Remedy Implemented: March 14, 2024

NC #007 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
i. the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,
ii. any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions,
iii. the role of the Residents' Council and Family Council, if any, in actions taken under subparagraphs i and ii,
iv. the role of the continuous quality improvement committee in actions taken under subparagraphs i and ii, and
v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that their continuous quality improvement report, published on their website included a written record of the dates the actions were implemented and the outcomes of the actions taken in response to improvement in the home, care, services, program and goods based on the results of the survey taken during the fiscal year under clause 43 (5) (b) of the act; any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions; the role of the Residents' Council and Family Council, in actions taken under subparagraphs i and ii; the role of the continuous quality improvement committee in actions taken under subparagraphs i and ii; and v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, and members of the staff of the home.

Rationale and Summary

A review of Wentworth Lodge's website included their March 30, 2023, QIP Narrative for Health Care Organizations in Ontario and Workplan Report.
The reports did not include a written record of the dates the actions were implemented and the outcomes of the actions taken in response to improvement in the home, care, services, program and goods based on the results of the survey taken during the fiscal year under clause 43 (5) (b) of the act; any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions; the role of the Residents' Council and Family Council, in actions taken under subparagraphs i and ii; the role of the continuous quality improvement committee in actions taken under subparagraphs i and ii; and how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and

their families, the Residents' Council, Family Council, and members of the staff of the home.
The Manager of Quality Improvement and Privacy acknowledged that the information as required was not included in the published continuous quality improvement report, nor was the information located elsewhere on the website. The following day the website was updated and included the required information.

Sources: Review of the Wentworth Lodge's website including the narrative report and interview with the Manager of Quality Improvement and Privacy.
[506]

Date Remedy Implemented: March 14, 2024

WRITTEN NOTIFICATION: Bathing

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that a resident was bathed by the method of their choice.

Rationale and Summary
The plan of care noted that a resident preferred baths, Point of care records identified that the resident was provided a bed bath on three occasions in February

2024. The record did not include documentation to support why the preferred method of bathing was not completed.
Failure to provide bathing by the resident's method of choice had the potential for dissatisfaction.

Sources: Review of plan of care; progress notes and point of care records for a resident; interviews with RPN and other staff.
[168]

WRITTEN NOTIFICATION: Dining and snack service

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 1.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.

The licensee has failed to ensure that the seven-day and daily menus were communicated to the residents.

Rationale and Summary
In March 2024, observation of a meal service identified that the residents had a choice of chicken salad on a bun or pizza. Interview with the Dietary Aide (DA) identified residents who were on a pureed diet would not be able to have pizza as the kitchen does not puree pizza and the residents who chose pizza would be given chicken cacciatore. This change in the menu was not communicated to the residents who required a pureed diet and chose pizza for their meal option.

Sources: Observation of meal service and menu board; interview with DA and other staff.
[506]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard, April 2022, issued by the Director was complied with.

Rationale and Summary
Specifically, the licensee failed to ensure that the IPAC standard section 9.1 (e) and (f) were followed, at a minimum, that additional precautions included point-of-care signage that indicated that enhanced IPAC control measures were in place and additional personal protective equipment (PPE) requirements including appropriate selection application, removal and disposal were complied with.

A resident's plan of care noted the resident was on contact precautions.
Observations of the resident's room and door did not include signage for contact precautions nor was PPE present at the point of care.
Failure to provide point of care signage and PPE had the potential to spread an infection.

Sources: Care plan review; observations of a resident and their environment; interviews with the IPAC lead and other staff.
[168]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that on every shift symptoms were recorded.

Rational and Summary
Progress notes identified that a resident presented with an infection in March 2024. Review of the documentation did not include that the symptoms of infection were recorded on every shift while the resident had the infection.

Sources: Progress notes and vital signs of a resident and interview with IPAC Lead.
[168]