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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: September 24, 2024

Inspection Number: 2024-1593-0004

Inspection Type:
Complaint
Critical Incident

Licensee: City of Hamilton

Long Term Care Home and City: Wentworth Lodge, Dundas

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 14-15, 20-23, 2024 and September 4-6, 9-10, 2024.

The following intake(s) were inspected:

- Complaint #00121068 regarding falls prevention and management.
- Critical Incident #00121360 regarding infection prevention and control.

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

Infection Prevention and Control
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 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

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

Rationale and Summary

A resident's plan of care noted a specified intervention was to be in place to communicate a safety risk.

During the inspection, the intervention was not in place during an observation of the resident.

The resident was later observed with the intervention in place, as required.

Sources: A resident's plan of care, observation of a resident, interview with staff.

Date Remedy Implemented: August 15, 2024

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 has failed to ensure there was a written plan of care for each resident that set out the planned care for the resident.

Rationale and Summary

Specific interventions were used to support a resident with toileting.

Planned care for the resident was to be documented in the kardex as well as the care plan. No interventions for toileting were documented in the kardex. The care plan document contained some but not all interventions.

Failure to ensure planned care was included in the written plan of care had potential for risk of harm to the resident as the interventions related to their safety and well-being.

Sources: A resident's written plan of care, interviews with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Rationale and Summary

A resident's plan of care included falls interventions. Staff reported the interventions were in place; however, the clinical record did not include documentation to confirm that the interventions were provided.

Failure to ensure that the care provided to the resident was documented may have diminished accountability of the staff providing the care.

Sources: Interviews with staff, a resident's plan of care and documentation records.

WRITTEN NOTIFICATION: Required Programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident

has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident had fallen, the resident was assessed and a post-fall assessment was conducted using a clinically appropriate assessment instrument specifically designed for falls.

Rationale and Summary

A resident experienced an unwitnessed fall.

The home's post-fall assessment protocol required a Falls Risk Screen including SCOTT's be completed after each fall and to initiate Head Injury Routine (HIR), for all unwitnessed falls.

The clinical record did not include all post fall assessment requirements set out in the home's falls policy after the fall.

Failure to complete all post-fall assessment tasks increased potential for risk of harm to the resident.

Sources: A resident's clinical record, interview with staff, the home's Falls Prevention and Injury Program policy.

WRITTEN NOTIFICATION: Required Programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Rationale and Summary

A resident demonstrated specified behaviours.

Staff reported a known trigger for the behaviours as well as interventions used to respond to their behaviours.

The care plan did not include documentation on the behaviours, trigger or interventions.

Not documenting care needs regarding behaviours had potential to increase risk of harm to the resident.

Sources: A resident's care plan and progress notes, an observation, interviews with staff.

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. Conduct audits twice weekly on a specified home area for a period of four weeks to ensure residents receive assistance with hand hygiene before eating at meals, and registered nursing staff use appropriate techniques when using alcohol-based hand rub (ABHR) during medication pass. Maintain a record of the audits, including the staff completing the audits, dates, times audits were completed, and any corrective action taken, if necessary.

2. Provide education to an identified staff on the four moments of hand hygiene. Maintain a record of the education provided, including the content covered, date, name and signature of staff receiving the education as well as the person providing the education.

Grounds

The licensee has failed to implement the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, issued by the Director.

1. The IPAC Standard for Long-Term Care Homes, revised September 2023, indicates under Section 9.1 Routine and Additional Precautions, that at minimum, Routine Practices, shall include (a) use of infectious disease risk assessments including point of care risk assessments (PCRAs).

During the inspection, a staff interacted with a resident and their environment without wearing personal protective equipment (PPE) when the resident was on additional precautions.

Signage was posted at the resident's door instructing use of PPE and PPE supplies were also available at the doorway.

Staff reported they did not see the signage before they entered the room and acknowledged PPE was required.

Failure to make a PCRA before every resident interaction and/or interaction with a resident's environment had potential to increase risk of transmission of infection.

Sources: Observation of a staff, interviews with staff.

2. The IPAC Standard for Long-Term Care Homes indicates under Section 9.1 Routine and Additional Precautions, that at minimum, Routine Practices shall include (b) hand hygiene, including, but not limited to, at the four moments of hand hygiene.

Two staff did not perform hand hygiene according to the four moments of hand hygiene.

One staff did not apply ABHR properly for a period of 15 seconds between interactions with residents during medication pass. Another staff did not perform

hand hygiene after interacting with a resident's environment.

Failure to use ABHR appropriately or when indicated had potential to increase risk of transmission of infection.

Sources: Observations of two staff, interviews with three staff.

3. The IPAC Standard for Long-Term Care Homes indicates under Section 9.1 Routine and Additional Precautions, that at minimum, Additional Precautions shall include (f) appropriate selection application, removal and disposal of PPE.

During the inspection, a staff member failed to remove and dispose of a PPE item after interacting with a resident on Additional Precautions.

Failing to follow requirements for appropriate removal of PPE had potential to increase risk of transmission of infection.

Sources: Observation of a staff, interviews with staff.

4. The IPAC Standard for Long-Term Care Homes indicates under Section 10.2, the hand hygiene program for residents shall include (c) assistance to residents to perform hand hygiene before meals.

During the inspection, hand hygiene was not offered to residents on an identified home area before a meal.

Failure to ensure hand hygiene was performed or offered when indicated had potential to increase risk of transmission of infection.

Sources: A meal observation, interviews with staff.

This order must be complied with by November 5, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.