

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Rapport d'inspection en vertu de
la Loi de 2007 sur les foyers de
soins de longue durée**

**Long-Term Care Operations Division
Long-Term Care Inspections Branch**

**Division des opérations relatives aux
soins de longue durée
Inspection de soins de longue durée**

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
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Bureau régional de services de
Hamilton
119, rue King Ouest 11^{ième} étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 10, 2020	2020_560632_0013	018205-20, 019216-20	Complaint

Licensee/Titulaire de permis

City of Hamilton
28 James Street North 4th Floor HAMILTON ON L8R 2K1

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

YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 6, 7, 8, 13, 14, 15, 16, 19, 20, 21 (on-site), October 22, 26, 27, 2020 (off-site).

**The following Complaint inspection was completed:
log #019216-20 and #018205-20 - related to abuse and neglect, falls prevention,
nutrition and hydration and accommodation services - maintenance.**

**Critical Incident System (CIS) # 2020_560632_0014 was conducted concurrently
with this inspection:**

**log #015747-20 - related to falls preventions,
log #016197-20 - related to medications,
log #017670-20 and #018675-20 - related to prevention of abuse and neglect.**

**During the course of the inspection, the inspector(s) spoke with the Administrator,
Director of Nursing (DON), Nurse Manager #1, Nurse Manager #2, Utility
Maintenance Operator, Physiotherapist, Registered Nurses (RNs), Registered
Practical Nurses (RPNs), and Personal Support Workers (PSWs).**

**During the course of the inspection, the inspectors observed resident and staff
interactions, and reviewed clinical health records, relevant home policies and
procedures, and other pertinent documents.**

The following Inspection Protocols were used during this inspection:

**Accommodation Services - Maintenance
Falls Prevention
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation**

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

**3 WN(s)
2 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting the resident.

A review of resident #004's progress notes indicated that the resident was transferred unsafely when staff used specified assistive device. A review of the resident's care plan identified a specified transfer intervention when the specified assistive device was used. The Lift and Transfer Assessment indicated that the resident's capacity to support themselves was specifically assessed. Initial Skin and Wound Assessment indicated that after the specified activity the resident's skin integrity was altered.

As a result of the specified activity, the resident sustained altered skin integrity and pain.

Sources: progress notes, care plan, Lift and Transfer Assessment, Risk Management Report, Initial Skin and Wound Assessment, interviews with PSWs #120 and #121. [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

**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).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for resident #004 that set out clear directions to staff and others who provided direct care to the resident related to specified assistive device used for specified activity.

A review of the resident #004's care plan identified a specified transfer interventions related to a specified activity involving the resident. The care plan did not include documentation in relation to a specified assistive device to be used by the resident for the specified activity.

The Lift and Transfer Assessment indicated that the specified assistive device was required for the resident's specified activity but lacked additional information required in the Assessment. The RN indicated that the additional information was not documented correctly in the Lift and Transfer Assessment. They indicated that staff used the specified assistive device with known information based on the resident. During the inspection, the PSWs confirmed that they used the information about the resident to direct the particulars associated with the lift and transfer. The PSWs also confirmed that they referred to the resident's care plan or to Kardex for the information. The RPN confirmed that there was no specified information included in the written resident's plan of care.

The resident was at risk of injury as their plan of care did not set out clear directions to staff and others, who provided direct care to the resident.

Sources: care plan, Lift and Transfer Assessment, interviews with PSWs #120 and #121, RN #113 and RPN #118. [s. 6. (1) (c)]

2. The licensee failed to ensure that the staff and others involved in the different aspects of care of resident #004 collaborated with each other: (a) in the assessment of the resident so that their assessments, related to the specified assistive device used by the resident during transfers, were integrated and were consistent with and complemented each other.

Care plan review for resident #004 indicated specified interventions for specified activity. The Lift and Transfer Assessments conducted for a specified period of time in 2020 indicated that the specified assistive device was required for the resident's specified activity, however the documentation in Lift and Transfer Assessments were either not complete or indicated inconsistency in measurements, which resulted in inconsistent choices of the available specified assistive devices.

During the inspection, the PSWs indicated that they used the specified assistive device with specified colour for specified activity involving the resident.

The RN indicated that the details of the specified assistive device were not documented correctly in the Lift and Transfer Assessment. The RN identified that PSW staff used a specific aide based on the resident's assessment, that was confirmed by PSW staff during the inspection. The RPN indicated that they did not remember the reason for not documenting the details of the specified assistive device for the resident in the Lift and Transfer Assessment that they completed.

During the inspection, the Nurse Manager indicated that the registered staff was to measure the residents' specified assistive devices with each Lift and Transfer Assessment.

The resident was at risk of injury as a result of the Lift and Transfer Assessments not being integrated and being inconsistent and not complementing each other, specifically in relation to the appropriate details of the specified assistive device.

Sources: care plan, Lift and Transfer Assessments (dates: February 19, May 13, May 28

and August 26, 2020), interviews with PSWs #120 and #121, RN #113, RPN #118, the Nurse Manager #1. [s. 6. (4) (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 and ensuring that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident and the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee did not ensure that procedures were implemented to ensure that electrical and non-electrical equipment, were kept in good repair and maintained at a level that met manufacturer's specifications.

Progress notes review indicated that resident #004 was involved in an unsafe transfer. A review of the resident #004's care plan identified specified interventions for transfers related to specified activity involving the resident.

During the inspection, the PSWs indicated that they visually checked the specified assistive device and its visible parts before each use.

Review of the Specified assistive devices Instructions for use directed the users to complete a list of mandatory daily checks and to perform periodic testing at weekly intervals and to check them before and after every use against a list of deviations. It was also recommended that qualified personnel inspected the condition of the assistive devices twice a year (every six month), according to ISO 10535.

Review the home`s Lift and Transfer Policy stated that all specified assistive devices were checked at the beginning of every shift. No information on specifically what should be checked to ensure equipment safety was included.

The Utility Maintenance Operator indicated that the specified assistive device equipment maintenance was completed by Arjo company representative. The Administrator indicated that the PSWs visually checked the specified assistive devices and there was no preventative maintenance done by Arjo company representative in 2020 at the time of the inspection. The Administrator confirmed that there were no procedure and no documentation process implemented in the home on safety checks of the specified assistive devices by staff.

The residents were at risk of injury as a result of safety check procedures not being developed and implemented to ensure that the specified assistive devices were kept in good repair and maintained at a level that met manufacturers' specifications at a minimum.

Sources: care plan, progress notes, Lift and Transfer Policy, Arjohuntleigh Getinge Group Maxi Move Instructions for Use, Passive Clip Slings Instructions for Use, interviews with PSWs #120 and #121, the Utility Maintenance Operator and the Administrator. [s. 90. (2) (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 and ensuring that procedures are implemented to ensure that electrical and non-electrical equipment, are kept in good repair and maintained at a level that meet manufacturer's specifications, to be implemented voluntarily.

Issued on this 18th day of November, 2020

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

Original report signed by the inspector.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : YULIYA FEDOTOVA (632)

Inspection No. /

No de l'inspection : 2020_560632_0013

Log No. /

No de registre : 018205-20, 019216-20

Type of Inspection /

Genre d'inspection: Complaint

Report Date(s) /

Date(s) du Rapport : Nov 10, 2020

Licensee /

Titulaire de permis : City of Hamilton
28 James Street North, 4th Floor, HAMILTON, ON,
L8R-2K1

LTC Home /

Foyer de SLD : Wentworth Lodge
41 South Street West, DUNDAS, ON, L9H-4C4

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : Karen Allcroft

To City of Hamilton, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

Order # /**No d'ordre :** 001**Order Type /****Genre d'ordre :** Compliance Orders, s. 153. (1) (a)**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must comply with s. 36 of O. Reg. 79/10, s. 36.

Specifically, the licensee must:

- ensure safe specified activity of all residents, by PSWs #120 and #121, who required the use of the specified assistive devices;
- ensure that the specified assistive devices were maintained and assessed by PSWs #120 and #121;
- re-educate PSWs #120 and #121 on the use of safe specified activity techniques, when using the specified assistive devices in the home;
- perform an audit to ensure that safe specified activity was provided by PSWs #120 and #121 to the residents when the specified assistive devices were used. The audit must be documented and identify who completed the audit.

Grounds / Motifs :

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting the resident.

A review of resident #004's progress notes indicated that the resident was transferred unsafely when staff used specified assistive device. A review of the resident's care plan identified a specified transfer intervention when the specified assistive device was used. The Lift and Transfer Assessment indicated that the resident's capacity to support themselves was specifically assessed. Initial Skin and Wound Assessment indicated that after the specified activity the resident's skin integrity was altered.

As a result of the specified activity, the resident sustained altered skin integrity and pain.

Sources: progress notes, care plan, Lift and Transfer Assessment, Risk Management Report, Initial Skin and Wound Assessment, interviews with PSWs #120 and #121.

An order was made by taking the following factors into account:

Severity: there was actual harm to resident #004 as the unsafe specified activity resulted in altered skin integrity and the resident experienced pain.

Scope: the scope of this non-compliance was isolated, because the safe specified activity was not completed for one out of three residents.

Compliance history: in the last 36 months, the licensee was not found to be non-compliant with s. 36 of the O. Reg. 79/10. In the past 36 months, four other COs were issued to different sections and subsections of the legislation, all of which have been complied.

(632)

**This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :**

Dec 21, 2020

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

**RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX
APPELS**

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le/la titulaire de permis souhaite que le directeur examine;
- c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11^e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière
d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 10th day of November, 2020

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : Yuliya Fedotova

Service Area Office /

Bureau régional de services : Hamilton Service Area Office