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

Division de la responsabilisation et de la performance du système de santé
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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
Jan 30, 2015	2015_267528_0003	H-001138-14, H-001583-14	Critical Incident System

Licensee/Titulaire de permis

BARTON RETIREMENT INC.
1430 UPPER WELLINGTON STREET HAMILTON ON L9A 5H3

Long-Term Care Home/Foyer de soins de longue durée

THE WELLINGTON NURSING HOME
1430 UPPER WELLINGTON STREET HAMILTON ON L9A 5H3

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

CYNTHIA DITOMASSO (528)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 26 - 28, 2015

This inspection was done concurrently with Complaint Inspection Log #: H-001665-14 and Follow Up Inspection Log #'s:H-001650-14, H-001651-14

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), Social Worker (SW), Physiotherapist (PT), and residents and families.

The inspector also toured the home, observed the provision of care and services, reviewed documents including but not limited to: policies and procedures, clinical health records, and log reports

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
2 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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(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. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours.

A. In November 2014, two PSWs provided incontinent care to resident #201. The resident was resistive to care, verbally and physically aggressive, was thrashing arms and yelling. After the care was provided, the PSWs noted a new area of altered skin integrity and reported events to registered staff.
i. Review of the plan of care for the resident indicated that the resident had a history of resistance to care with verbal and physical aggression. Interventions directed staff to leave the resident and reapproach at a later time, as the resident required multiple attempts and encouragement.
ii. Interview with the PSW confirmed incontinent care was provided to the resident although they were resistive. The PSW's denied touching the new area of altered skin integrity developed; however, indicated that they resident could have sustained an injury when thrashing their limbs.
iii. Interview with the DOC and PSWs who provided care confirmed that strategies developed and outlined in resident #201's plan of care, related to resistance to care, were not implemented. [s. 53. (4) (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 to ensure that for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents.

In August 2014, two staff members observed a PSW lifting their leg towards resident #200.

i. Review of the plan of care for resident #200 indicated that the resident had advanced dementia and displayed responsive behaviours including but not limited to, resistance to care which escalated into physical protective behaviours. A Broset Voilence Assessment completed in March 2014, determined that the resident was at a high risk for violence and aggression. Interventions included having two staff members present during care so that one staff member can distract the resident from hitting out.
ii. On January 27, 2015, an interview was held with the PSW who was observed lifting their leg towards the resident. They described that they often lifted an extremity towards the resident when the resident was being aggressive and hitting out, and that the action was done so that the resident would attempt to hit the staff member. The PSW claimed that the resident "got it out of their system", and would not strike out any further.
iii. Interview with another PSW and RPN confirmed that the action of having the resident hit a staff member was not part of the interventions developed for the resident.
iv. In an interview with the DOC and review of the home's investigation notes from the incident, the home was unable to confirm if resident #200 was struck by the PSW's leg. The PSW was disciplined by the home.

Interventions to assist residents and staff who were at risk of harm as a result of resident's behaviours were not implemented by the PSW. Instead of distracting resident #200 from hitting out, as outlined in their plan of care, both the PSW involved and the DOC confirmed that the aggressive behaviour was encouraged or provoked by the PSW's actions. [s. 55. (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 to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents., to be implemented voluntarily.

Issued on this 5th day of February, 2015

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
C DiTomasso #528

Original report signed by the inspector.