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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Jun 23, 2016	2016_267528_0014	011490-16	Complaint

Licensee/Titulaire de permis

CITY OF HAMILTON
77 James Street North, Suite 400 HAMILTON ON L8R 2K3

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

CYNTHIA DITOMASSO (528)

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): June 20 and 21, 2016

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Nurse Manager, the Physician, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW)

The following Inspection Protocols were used during this inspection:
Personal Support Services

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

2 WN(s)
0 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 LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident, the SDM, if any, and the designate of the resident / SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.

A. In 2016, resident #010 was admitted to the home. The resident had two substitute decision makers (SDM), who were listed in the resident's plan of care as Powers of Attorney (POA) for care. Review of the plan of care identified the following examples where neither SDM was notified of changes in the plan:

i. In February 2016, registered staff documented that the resident had ongoing areas of altered skin integrity and a referral was made to the Nurse Practitioner. Interview with the Nurse Practitioner (NP) identified that they assessed the resident and new treatment was ordered. Review of the plan of care did not include any consent or notification from either SDM related to wound treatment orders, until after the treatment was completed and the wound was dressed, when the SDM observed the new dressing. Progress notes and interview with the NP confirmed that the SDM did not agree to certain aspects of wound dressing, and was upset the home did not inform them prior to doing the treatment and putting on the dressing.

ii. In March 2016, the resident had an unwitnessed fall resulting in an injury. Review of the plan of care did not include any documentation of the fall until the following day, at which time, the POA was notified. Interview with registered staff #100 and #101 and PSW #102, confirmed that the SDM was not notified of the fall until the following day.

iii. At a care conference in April 2016, the interdisciplinary team, including both SDMs , met to discuss the course of treatment for the resident. Over the next four weeks, the condition of the resident continued to deteriorate. An increase in behavioural symptoms was documented on an identified night in May 2016. Interview with registered staff #103 confirmed that the resident's behavioural symptoms were constant. Interview with

registered staff #103 and #104 also identified that staff continuously monitored the resident. Medications for the resident were administered but ineffective. In the morning, registered staff #103 suggested to registered #104 a new intervention to prevent injury. The intervention was approved by registered staff #101 and put in place and a message was left for one of the SDMs. At the same time, the second SDM came in to visit and found the resident on the floor in their room with no clothes on, which upset both SDMs.

Interview with registered staff #103 and registered staff #104 confirmed that the SDMs were not notified of the resident's increase in behaviours during the night or the home's decision to trial a new intervention, until after the intervention was in place. The SDMs were therefore not involved in the development of the plan on how to keep the resident safe during the end stage of their disease. Interview with registered staff #105 identified that staff should have called the family, as the resident was palliative and was more calm when one of the SDMs were with them.

iv. The SDMs for resident #010 were not notified of the above changes in the plan until after the interventions were in place, and therefore were not fully included in the development of the plan.

B. In May 2016, resident #011 was admitted to the home. Approximately four weeks later, registered staff documented two new areas of altered skin integrity. Review of the plan of care and registered staff communication calendar did not include any documentation to support that the SDM was notified of the new areas of altered skin integrity. Interview with registered staff #106 confirmed that the SDM for resident #011 was not notified of two new areas of altered skin integrity, and therefore, was not included in the development and implementation in the resident's plan of care, related to skin and wound care. [s. 6. (5)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record was kept in the home that included,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

A. In April and May 2016, the SDM for resident #010 expressed care concerns to the Social Worker, who notified the DOC and Nurse Manager. Review of the "2016 Compliments, Opportunities for Improvements and Concerns Log", did not include the concerns from April and May 2016. Interview with the registered staff #104, #100, #107, #108, the NM, and the DOC, confirmed that a care conference was held, along with subsequent conversations via telephone, email and in person, with the both SDMs and the interdisciplinary team; however, was not included as part of the 2016 Concern Log, as required in the legislation. [s. 101. (2)]

Issued on this 13th day of July, 2016

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

Original report signed by the inspector.