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 prévue 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 # / No de registre	Type of Inspection / Genre d'inspection
Aug 22, 2019	2019_560632_0018	013703-19	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): July 24, 25, 26, 29, 30, 31, 2019.

The following Complaint inspection was conducted:
log #013703-19 - related to Prevention of Abuse, Neglect and Retaliation.

The following Critical Incident System (CIS) inspection #2019_560632_0019 was conducted concurrently with this inspection:
log #012809-19 - related to Prevention of Abuse, Neglect and Retaliation.
log #014124-19 - related to Responsive Behaviors.
log #014010-19 - related to Falls Prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Nurse Practitioner, Nurse Manger #1 (NM #1), Nurse Manager #2 (NM #2), Social Worker, Administrative Assistant, personal support workers (PSWs), registered nurses (RNs), registered practical nurses (RPNs), residents and their families.

During the course of the inspection, the inspector(s) observed the provision of care and services, reviewed documentation, including, clinical health records, policies and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

During the course of this inspection, Administrative Monetary Penalties (AMP) were not issued.
- **0 AMP(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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

WN #1: 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. (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 resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Complaint log #013703-19 (IL-68333-HA) and Critical Incident System (CIS) log #012809 -19 (CI M592-000029-19) submitted to the Ministry of Long-Term Care (MOLTC) regarding allegations of abuse, were reviewed.

Resident #001's specified assessments suggested a cognitive diagnosis.

According to the clinical records on an identified date in 2019, and interview with RN #104 and RPN #107, resident #001 had experienced specified activities involving RPN #017.

Review of one of the homes specified protocols identified the activity could occur with a responsible person. Review of the Resident Care and Services Manual Policy indicated that the SDM would be notified of the activity (if unaware) and RPN and/or RN would inform the SDM, so that a responsible party might participate in the activity with the resident.

Interview with RPN #107 during the inspection it was identified that they were under the impression that the resident's Substitute Decision Maker (SDM) was involved in specified activity with the resident.

Interview with the DON during the inspection it was identified that according to the home's policy staff was expected to notify the SDM that the specified activity was going to occur, which was not done.

The licensee failed to ensure that the resident's substitute decision-maker was given an opportunity to participate fully in the implementation of the resident's plan of care, when resident #001 was involved in the specified activity. [s. 6. (5)]

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 the resident's substitute decision-maker is given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

Issued on this 29th day of August, 2019

[redacted]

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

Original report signed by the inspector.