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_0004	H-001665-14	Complaint

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 Complaint inspection.

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

This inspection was done concurrently with Critical Incident System Inspection Log#'s: H-001138-14, H-001583-14 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:
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
3 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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied with related to s.20(2)d, the duty under section 24 to make mandatory reports.

A. The home's "Abuse Policy:NUR-II-02 ADM-VI-06", last revised January 2003, outlined that all abuse of a resident by anyone is to be reported to the Ministry of Health and Long Term Care (MOHLTC).

i. In November 2014, resident #101 had three instances of inappropriately touching. The plan of care for all three residents identified moderate to severe cognitive impairment. Notification of the SDMs and police was completed after each incident.
ii. Two out of the three incidents were not reported to the MOHLTC.
iii. The third incident of inappropriate touching was reported five days after the incident occurred.
iv. Interview with the ADOC confirmed that reporting to the MOHLTC was not completed immediately as required in section 24 to make mandatory reports. [s. 20. (1)]

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 the home's policy to promote zero tolerance of abuse and neglect of residents was complied with related to s.20(2)d, the duty under section 24 to make mandatory reports, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

The plan of care for resident #101 indicated moderate cognitive impairment with a history of responsive behaviours including, but not limited to, inappropriate touching of co-residents and staff.

i. Review of the progress notes from November 2014, identified that two of the incidents of inappropriate touching of co-residents occurred in the dining room and one in a resident's room.
ii. The Behavioural Symptoms Resident Assessment Protocols (RAPs) from October 2014, identified sexually inappropriate touching and outlined an intervention for staff to redirect the resident.
iii. At the beginning of November 2014, registered staff documented an incident of resident #101 inappropriately touching resident #100 in the dining room. On an evening later that month, registered staff documented an incident of resident #101 entering co-resident's room and inappropriately touching resident #103.
iv. As a result of the documented incidents of inappropriately touching, resident #101 was escorted to and from the dining room to ensure they did not enter co-resident rooms. However, no interventions were implemented while resident #101 was in the dining room.

v. A third incident was documented at the end of November 2014, where resident #101 inappropriately touched resident #100 in the dining room.
vi. Interview with direct care and registered staff confirmed that they were aware of the resident's pattern of approaching residents in the dining room. Interview with the RPN working on the day of the last incident confirmed she watched the resident walk into the dining room and head straight for resident #100.

Steps were not taken to minimize the risk of altercations of inappropriate touching between resident #101 and resident #100 in the dining room until the third documented incident in November 2014, at which time a plan was created to prevent further altercations. No further documented incidents were noted after November 2014. [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

WN #3: 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. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

The family of resident #100 expressed concerns to registered staff twice in November 2014, three days apart, regarding the safety of resident #100.

Review of the progress notes for resident #100 identified that two altercations with another resident had occurred that month. Family members were concerned about the safety of resident #100 and registered staff documented those concerns in November 2014.
i. A plan was implemented in order to prevent any further altercations between the residents, which was shared with the family in November 2014, at which time, it was documented that the family members continued to have concerns.
ii. Review of the plan of care did not include documented resolution or follow up response with the family of resident #100 after November 2014.
iii. Interviewed with the current DOC, ADOC (acting DOC at the time of the incidents), and RN (acting ADOC at the time of the incidents), could not confirm any follow up discussion was had with the family of resident #100 after November 2014.
iv. Interview with an RPN who regularly speaks with the family of resident #100, confirmed that although no further altercations had occurred, the family continued to express concern.
v. Interview with the family of resident #100, revealed that although no further altercations had occurred, the family felt no formal follow up response was initiated by the home to discuss resolution or any further concerns.

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Issued on this 5th day of February, 2015

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

Original report signed by the inspector.