Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Mar 20, 2017	2017_539120_0015	000754-17	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

BERNADETTE SUSNIK (120)

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): February 23 & 24, 2017

000754-17 related to personal support services.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care,a Registered Nurse, Personal Support Workers and a family member.

During the course of the inspection, the inspector reviewed the resident's clinical records.

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

During the course of this inspection, Non-Compliances were issued.
1 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.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The written plan of care for resident #200 included a focus geared towards the improvement of blood flow/circulation. The intervention included the application of a specialized clothing item to be applied "in the am and off in the pm". The specialized clothing item was prescribed by the resident's physician in December 2015, and discontinued in April 2016 due to the resident's non-compliance in wearing the clothing item. The resident was re-assessed by a physician in May 2016, and an order re-instated and a note made that the resident would be needing the clothing item long term.

The resident's substitute decision maker (SDM) identified that on several occasions in 2016, the specialized clothing item went missing and could not be found for a few days or never found. According to the resident's progress notes, the clothing item most recently went missing beginning in February 2017. The resident's personal support worker reported that they recalled that the clothing item was applied on a particular morning and by the evening, the resident had taken the item off. The PSW reported that the resident didn't like wearing the clothing item and that it was well known to many staff members that the resident removed the item regularly. A search was initiated and the clothing item was not found. As of the date of the inspection, the clothing item had not been found and the resident had not been provided with the clothing item or an alternative. No documentation was made in the residents clinical record with respect to contacting the resident's SDM about the missing clothing item or any plans to have the item replaced. No interventions were included in the plan of care to identify that the resident did not like

to wear the clothing item, that they often removed the clothing item and how staff would be required to ensure that the clothing item was applied as per doctor's order.

The licensee did not ensure that resident #200 had the daily application of a specialized clothing item applied in the morning and off in the evening. [s. 6. (7)]

2. The licensee did not ensure that the plan of care was reviewed and revised at any time when the resident's care needs changed or care set out in the plan was no longer necessary.

Resident #200 received a skin assessment in July 2016, at which time a Registered Nurse identified a specific condition. The resident was assessed by a physician in early August 2016, to have the specific condition. A treatment was prescribed and was started on the same date. Twenty days later, a physicians note identified that the treatment did not appear to be working and to continue the treatment until the container was empty. According to the Director of Care, the treatment ended in early December 2016. A registered nurse confirmed that the treatment was no longer being given during the inspection. However, in mid January 2017, a "Nursing Quarterly Summary" identified that the resident was still receiving a treatment for the condition. The resident's plan of care included that the treatment was resolved as of the end of January 2017. No clinical notes were made as to whether the resident was re-assessed (by a specialist or Physician). The Director of Care confirmed that the resident should be re-assessed and would make arrangements to do so.

The licensee did not ensure that the care plan was reviewed and revised when the specific treatment for the resident's condition ended in early December 2016. [s. 6. (10)(b)]

Issued on this 20th day of March, 2017

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

Original report signed by the inspector.