Ontario

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 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 29, 2019	2019_704682_0029	011703-19, 013612-19	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

AILEEN GRABA (682)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 22, 23, 24, 25, 2019.

The following Critical Incident Inspections were conducted:
011703-19 related to fall prevention
013612-19 related to fall prevention

The following Compliance Order Follow Up Inspection 2019_704682_0030 was conducted concurrently:
014021-19 related to prevention of abuse

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Care (DOC); Registered Staff; Personal Support Workers (PSW) and residents

During the course of the inspection, the inspector toured the home; reviewed resident health records, meeting minutes, training records and attendance, policies and procedures, staffing schedules, Critical Incident System (CIS) submissions, observed residents and the provision of care.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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	Légende 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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment was maintained in a safe condition and in a good state of repair.

A critical incident (CI) was submitted to the Director.

A clinical record review identified resident #001 was a fall risk. Further review included the written plan of care for resident #001 which identified various interventions in place. Progress notes, written by staff #101 stated that resident #001 sustained a fall and the equipment/intervention was not in a safe condition.

During an interview staff #101 stated that resident #001 intervention was not in working condition. Staff #101 stated they identified and corrected the concern with the equipment/intervention. Staff #101 confirmed that resident's #001 fall prevention intervention was not in working condition. The home failed to ensure resident's #001 equipment was in a safe condition and in a good state of repair. [s. 15. (2) (c)]

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, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The following is further evidence to support Compliance Order #002 issued on August 20, 2019, during complaint inspection 2019_539120_0027 to be complied December 31, 2019.

The licensee failed to ensure that where the Act and Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 48 (1) 1, and in reference to O. Reg. 79/10, s. 49 (1), the licensee was required to have a falls prevention and management program that provided strategies to reduce or mitigate falls, including the monitoring of residents.

A) CI was submitted to the Director.

A clinical record review indicated that resident #001 was identified as a fall risk. A review of the care plan identified that resident #001 had various fall prevention strategies.

During observations by Inspector #682, resident #001 did not have a fall prevention strategy in place. During interviews, both staff #101 and staff #103 acknowledged that resident #001 did not have the fall prevention strategy in place. During observations by Inspector #682 resident #001 was in an area of the home and staff #104 acknowledged that resident's #001 did not have the fall strategy in place.

B) CI log was submitted to the Director.

A clinical record review indicated that resident #002 was identified as a fall risk. A review of the care plan identified various fall prevention strategies.

During observations by Inspector #682, resident #002 did not have the fall prevention strategy in place. During an interview staff #103, confirmed that the fall prevention strategy was not in place. Staff #103 confirmed that the fall prevention strategy was not in place for resident #002 as stated in the home's policy.

The licensee failed to ensure that staff complied with the fall prevention policy [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 29th day of October, 2019

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

Original report signed by the inspector.