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
Feb 9, 2015	2015_248214_0003	H-001821-15	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

CATHY FEDIASH (214)

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): January 13, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nursing Staff, Behavioural Supports Ontario (BSO). The inspector also reviewed relevant clinical records, policies and procedures and training records.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours

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 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 licensee failed to ensure that any plan, policy protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A review of resident #100's progress notes from identified dates in December 2014 and January 2015, indicated that the resident demonstrated known responsive behaviours that included physical and verbal aggression and resistance to care. A review of progress notes from identified dates in December 2014 and January 2015, indicated that the resident demonstrated several incidents of responsive behaviours.

A review of the home's policy, Risk Management (dated September 3, 2013) indicated the following:

All resident incidents will be thoroughly investigated, documented and followed up for purposes of resident safety, potential prevention and analysis. Incidents will be documented in Point Click Care and reported according to the following procedure:

-Resident Health Record, Progress Notes in PCC
-MOHLTC- Critical Incident System Report
-Risk Management Incident Report in PCC

An interview with the DOC confirmed that incidents involving the resident were not documented in the Risk Management section of Point Click Care (PCC) and that the home did not comply with their policy. [s. 8. (1) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that for each resident demonstrating responsive behaviours, that actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A review of resident #100's progress notes from identified dates in December 2014 and January 2015, indicated that the resident demonstrated known responsive behaviours that included physical and verbal aggression and resistance to care.

i) According to the resident's progress notes, on an identified date in December 2014, during the early morning hours, the resident demonstrated responsive behaviours of physical aggression during morning (AM) care. No documentation was included regarding what actions were taken to respond to the needs of the resident or the resident's response to any interventions that were implemented.

ii) According to the resident's progress notes, on an identified date in December 2014, during the late morning hours, the resident began striking out at staff during care. No documentation was included regarding what actions were taken to respond to the needs of the resident or the resident's response to any interventions that were implemented.

iii) According to the resident's progress notes, on an identified date in December 2014, during medication administration, the resident became agitated and angry and told staff to go away. No documentation was included regarding what actions were taken to respond to the needs of the resident or the resident's response to any interventions that

were implemented.

iv) According to the resident's progress notes, on an identified date in December 2014, during medication administration, the resident refused their medications and hit and kicked staff when medication was offered. No documentation was included regarding what actions were taken to respond to the needs of the resident or the resident's response to any interventions that were implemented.

v) According to the resident's progress notes, on an identified date in December 2014, the resident was physically aggressive to staff during rounds. No documentation was included regarding what actions were taken to respond to the needs of the resident or the resident's response to any interventions that were implemented.

An interview with the Director of Care confirmed that documentation was not completed regarding actions taken to respond to the needs of the resident or the resident's response to any interventions that were implemented, for the incident's noted above. [s. 53. (4) (c)]

Issued on this 17th day of February, 2015

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

Original report signed by the inspector.