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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 25, 2019	2019_560632_0006	032356-18	Director Order Follow Up

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 Director Order Follow Up inspection.

This inspection was conducted on the following date(s): February 27, 28, March 4, 5, 6, 7, 8, 2019.

This was a Follow Up (FU) to an order issued by the Director [November 20, 2018] during Critical Incident System (CIS) Inspection 2018_689586_0022:

log #032356-18 was related to Prevention of Abuse, Neglect and Retaliation, Responsive Behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing (DON), Administrative Assistant, Nursing Clerk, Social Worker, Personal Support Workers (PSWs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Behavioural Support Ontario (BSO) RPN, residents and their families.

A follow up inspection to a Director Order (DO#001 served on 2018-12-10) concluded that the Director Order was complied with (s. 19. (1)).

Non-compliance related to O. Reg. 79/10, r. 54 (a) was identified during the FU inspection to a Director Order and was issued as a Voluntary Plan of Correction (VPC) on this Director Order Report.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	DO #001	2018_689586_0022	632

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 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 of a long-term care home failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including:
a) Identifying factors, based on interdisciplinary assessment and on information provided to the licensee or staff or through observation that could potentially trigger such altercations.

A. In February 2019, based on the registered staff's documentation in progress notes, resident #003 and resident #001 were witnessed demonstrating identified behaviour towards each other. Resident #003 had a history of identified behaviour in the home. Review of the written plan of care for resident #003 directed staff to follow identified interventions for resident #003 (initiated in January 2018). In March 2019, Behavioural Support Ontario (BSO) RPN #107 indicated that resident #003's identified transitional follow up was closed in February 2018, and, since that time, BSO RPN #107 did not receive any referrals from the home. Review of Identified Policy (reviewed in June 2018) indicated that the assessment of identified behaviour was to be achieved through a variety of formal and informal processes.

In March 2019, the DON identified that no re-assessments were completed after the February 2019's incident between resident #003 and #001 to identify additional steps to manage identified behaviour of resident #003.

The home failed to ensure that steps were taken to minimize the risk of identified behaviour between resident #003 and #001.

B. In February 2019, based on the registered staff's documentation in progress notes, resident #003 and resident #001 were witnessed demonstrating identified behaviour towards each other. Resident #001 had a history of identified behaviour in the home and, based on the review of the resident's written plan of care, the identified interventions were in place, which were initiated in December 2017 and in August 2018 and revised with no changes in December 2018. In March 2019, BSO RPN #107 indicated that resident #001's identified transitional follow up was closed in February 2018, and since that time, the BSO RPN #107 did not receive any referrals from the home. Review of identified Policy indicated that the assessment of identified behaviour was to be achieved through a variety of formal and informal processes.

In March 2019, DON identified that no re-assessments were completed to identify additional steps to manage identified behaviour of resident #001.

The home failed to ensure that steps were taken to minimize the risk of identified behaviour between resident #003 and #001. [s. 54. (a)]

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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including:
a) Identifying factors, based on interdisciplinary assessment and on information provided to the licensee or staff or through observation that could potentially trigger such altercations, to be implemented voluntarily.

Issued on this 4th day of April, 2019

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

Original report signed by the inspector.