Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 28, 2022	2022_848748_0003	004579-21, 006386-21, 007112-21, 007241-21, 009040-21, 011519-21, 013906-21, 014782-21	Critical Incident System

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

EMMY HARTMANN (748), YVONNE WALTON (169)

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): February 23, 24, 28, March 1, 2, 3, 8, 9, 10,15, 2022.

The following intakes were completed during this Critical Incident Inspection:

Log #004579-21 was related to resident to resident altercation.
Log #006386-21 was related to falls prevention.
Log #007112-21 was related to an allegation of resident to resident physical abuse.
Log #007241-21 was related to an allegation of resident to resident sexual abuse.
Log #009040-21 was related to falls prevention.
Log #011519-21 was related to a hypoglycemic episode with transfer to hospital.
Log #013906-21 was related to falls prevention.
Log #014782-21 was related to falls prevention.

During the course of the inspection, the inspector(s) spoke with residents, the Administrator, the Director of Care (DOC), Administrative Assistant, Manager of Quality Initiatives, Screeners, Recreationist, Housekeepers, Physician, Nurse Manager, registered nurses (RN), registered practical nurses (RPN), and personal support workers (PSW).

During the course of the inspection, the inspector also observed resident and staff interactions, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **1 VPC(s)**
- **1 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that two residents were protected from abuse.

A. Ontario Regulation 79/10 defined sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

On an identified date, resident #009 was witnessed inappropriately touching resident #005. Staff #123 and #124 stated that the resident #005 was not able to give consent due to a severe cognitive impairment.

Nurse Manager #131 confirmed that this incident met the definition of sexual abuse.

Sources: Resident #005 and resident #009's progress notes, the home's investigation notes; interviews with staff #123, staff #124, and Nurse Manager #131.

B. The Long Term Care Homes Act (LTCHA), 2007, defined physical abuse as the use of physical force by a resident that causes physical injury to another resident.

On an identified date, resident #007 sustained injuries after an interaction with resident #006.

Staff #123 verified that resident #007 sustained injuries after their interaction with resident #006.

Nurse Manager #131 acknowledged that this incident met the definition of physical abuse.

Sources: Resident #006 and resident #007's progress notes, resident #007's wound care assessment, the home's investigation notes; interviews with staff #123, and Nurse Manager #131. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that medication was administered to a resident in accordance with the directions for use specified by the prescriber.

A resident had a medical condition and was prescribed medication to be given when required, and specific directions were outlined by the doctor related to the medication's use.

On an identified date, the resident was not given the medication as per directions specified by the doctor in two instances.

The DOC verified that the medication was not given to the resident in accordance with the directions for use as specified by the doctor.

There was a risk that the resident's medical condition was not managed when they were not given the medication as prescribed by the doctor.

Sources: A resident's progress notes, eMAR; interview with DOC. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: 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 where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place a policy, the policy was complied with.

Ontario Regulation 79/10, section 114 (1) required the licensee to develop an interdisciplinary medication management system that provided safe medication management and optimized effective drug therapy outcomes for residents. Ontario Regulation 79/10, section 144 (2) and Ontario Regulation 79/10, section 144 (3) (a) required that the program included written policies and protocols that were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home, and that the policies were implemented.

Specifically, staff did not comply with the licensee’s policy, which stated that any as needed (prn) medication administered was to be documented in the auto-populated electronic progress notes noting the date and time the medication was given and the effect; and that documentation was to be accurate.

A resident had a medical condition and was prescribed medication to be given when required, and specific directions were outlined by the doctor related to the medication use.

On an identified date and time, staff #108 documented on the resident's auto populated progress note that the resident was given an amount of medication that was not the same as what the doctor outlined for it's use.

Two hours later, staff #108 documented a health status progress note but the note indicated that the resident was given a different amount of the medication.

There was a discrepancy in staff #108's documentation with regards to the amount of medication given to the resident.

Staff #108 said that after administration of the medication, the nurses were to manually enter the amount of the medication given into a box. The information entered here would be auto populated into the resident's progress notes. They identified that they made an error in their initial entry of the amount of the medication administered; and that the resident received the correct amount as reflected on their progress notes two hours later, on the same identified date.

The DOC identified that they expected staff to strike out documentation made in error, and complete another entry into the progress notes to capture the correct information. They verified that the progress note made in error was not struck out; and that the information documented in the resident's progress notes was not accurate.

Sources: A resident's progress notes, eMAR, the home's policy; interviews with staff #108, and DOC. [s. 8. (1) (b)]

Issued on this 4th day of April, 2022

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	EMMY HARTMANN (748), YVONNE WALTON (169)
Inspection No. / No de l’inspection :	2022_848748_0003
Log No. / No de registre :	004579-21, 006386-21, 007112-21, 007241-21, 009040-21, 011519-21, 013906-21, 014782-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 28, 2022
Licensee / Titulaire de permis :	City of Hamilton 28 James Street North, 4th Floor, Hamilton, ON, L8R-2K1
LTC Home / Foyer de SLD :	Wentworth Lodge 41 South Street West, Dundas, ON, L9H-4C4
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Karen Allcroft

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To City of Hamilton, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must comply with section 19 (1) of the LTCHA.

Specifically, the licensee shall ensure that:

1. Resident #005 is protected from sexual abuse by resident #009.
2. Resident #007 is protected from physical abuse by resident #006.

Grounds / Motifs :

1. 1. The licensee failed to ensure that two residents were protected from abuse.

A. Ontario Regulation 79/10 defined sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

On an identified date, resident #009 was witnessed inappropriately touching resident #005. Staff #123 and #124 stated that the resident #005 was not able to give consent due to a severe cognitive impairment.

Nurse Manager #131 confirmed that this incident met the definition of sexual abuse.

Sources: Resident #005 and resident #009's progress notes, the home's investigation notes; interviews with staff #123, staff #124, and Nurse Manager #131.

B. The Long Term Care Homes Act (LTCHA), 2007, defined physical abuse as

the use of physical force by a resident that causes physical injury to another resident.

On an identified date, resident #007 sustained injuries after an interaction with resident #006.

Staff #123 verified that resident #007 sustained injuries after their interaction with resident #006.

Nurse Manager #131 acknowledged that this incident met the definition of physical abuse.

Sources: Resident #006 and resident #007's progress notes, resident #007's wound care assessment, the home's investigation notes; interviews with staff #123, and Nurse Manager #131. [s. 19. (1)]

An order was made by taking the following factors into account:

Severity: There was minimal harm to residents #005 and #007 as result of the physical and sexual abuse.

Scope: There was a pattern of non-compliance in this area as two out of three residents reviewed, were not protected from abuse.

Compliance History: Four written notifications (WN); and three compliance orders (CO), were issued to the home related to the same section of the legislation in the past 36 months, all of which have been complied. (748)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 06, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 28th day of March, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Emmy Hartmann

Service Area Office /
Bureau régional de services : Hamilton Service Area Office