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

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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
Aug 31, 2020	2020_560632_0009	002471-20, 003119-20, 012774-20	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): July 24, 27, 28, 29, 30, 31, August 4, 5, 6, 7, 10, 2020.

The following intakes were completed during this Complaint inspection:
log #003119-20 - related to Prevention of Abuse and Neglect, Falls Prevention, Personal Support Services, Nutrition and Hydration,
log #002471-20 - related to Personal Support Services.

The following Critical Incident System (CIS) inspection was completed concurrently with this Complaint Inspection:
log #012774-20 - related to Falls Prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, Nurse Manager #1 (NM #1), Nurse Manager #2 (NM #2), Resident Assessment Instrument (RAI)/Minimum Data Set (MDS) and Restorative Care Co-ordinator, Personal Support Workers (PSWs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Nursing Clerk, residents and their families.

During the course of the inspection, the inspector(s) reviewed clinical records, policies, procedures, and practices within the home, reviewed meeting minutes, observed the provision of care and medication administration.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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)**

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. 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A Complaint Report was submitted to the Ministry of Long-Term Care (MLTC) in relation to the plan of care for resident #001 not being followed by the home on an identified date in June 2020.

Review of the written plan of care and Lift and Transfer Assessment indicated specific directions related to resident #001's transfer status.

Review of the Plan of Care Policy indicated that the plan of care was a communication tool and to be used by direct care team members across all departments and shifts. It provided the requisite direction on how to care for the resident based on the resident's identified needs and preferences.

During the inspection the NM #1 indicated that in the morning on an identified date in June 2020, the resident had an incident and staff used a specified transfer device on the resident.

During the inspection, PSW #107 and PSW #110 indicated that in the afternoon on the same identified date in June 2020, resident #001 expressed wishes to get support on their Activities of Daily Living (ADL). PSW #110 indicated that they assumed that the specified transfer device could be used for the resident based on previous communication with the RN #116, who reported that, in the morning of the same day, the specified transfer device was used for resident #001.

The licensee failed to ensure that the care set out in the plan of care, related to transfers, was provided as specified in the plan of care for resident #001. [s. 6. (7)]

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 the care set out in the plan of care, related to transfers, is provided as specified in the plan of care, to be implemented voluntarily.

Issued on this 8th day of September, 2020

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

Original report signed by the inspector.