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
Feb 5, 2020	2020_560632_0002	022566-19, 022808-19, 023126-19, 000686-20	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): January 6, 7, 8, 9, 13, 15, 16, 17, 20, 21, 22, 23, 24, 27, 28, 2020.

The following Complaint inspections were completed:
log #022566-19, 022808-19, 023126-19, 000686-20 - related to prevention of abuse and neglect, personal support services, nutrition and hydration, falls prevention and pain.

Critical Incident System (CIS) inspection #2020_543561_001 was conducted concurrently with this inspection:
log #015580-19 - related to Compliance Order (CO) Follow up,
log # 016082-19, 018043-19 - related to falls prevention,
log # 019902-19- related to medications,
log # 020866-19, 023322-19, 023794-19 - related to responsive behaviors,
log # 023530-19, 024354-19 - prevention of abuse and neglect, responsive behaviors,
log # 000289-20 - related to prevention of abuse and neglect.

Inspector #561 and Inspector #581 were present during this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Nurse Manager #1 (NM), NM #2, Resident Assessment Instrument (RAI)/Minimum Data Set (MDS) and Restorative Care Co-ordinator, Manager of Quality Initiative, Director of Food Services, Registered Dietitian (RD), Resident Services, Housekeeping and Laundry Supervisor, Administrative Assistant, Nursing Clerk, Social Worker (SW), Physiotherapist (PT), Dietary Aid (DA), personal support workers (PSWs), registered nurses (RNs), registered practical nurses (RPNs), residents and their families.

During the course of the inspection, the inspector(s) observed the provision of care and services, reviewed documentation, including, clinical health records, policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care

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

- **2 WN(s)**
- **2 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 based on an assessment of the resident and the needs and preferences of that resident.

Review resident #003's written plan of care indicated that the resident required assistance with staff for transfers and the use of transferring device for transfers. The level of assistance was to be changed at the time of task.

During the inspection, PSW #129 was interviewed and indicated that the assistance with transfers was provided to the resident.

Review of the most recent Lift and Transfer Assessment indicated that transfer device was to be used for all transfers. During the inspection, the PT indicated that no other transfer assessments were conducted for the resident. The registered staff were to complete the transfer assessment if needed and if the resident’s health status changed, the registered staff were to send a referral to the PT for the assessment.

During the inspection, the RAI/MDS and Restorative Care Co-ordinator indicated that the current care plan for resident #003 was updated and the registered staff were to assess the resident and to update the care plan based on the current situation.

Review resident #003's clinical records indicated that no Lift and Transfer assessment was conducted, since the care plan was updated, based on the current transfer status of the resident, which was acknowledged by the DON.

The licensee failed to ensure that the care set out in the plan of care in relation to transfers was based on an assessment of resident #003. [s. 6. (2)]

2. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A Complaint Report was submitted to the MOLTC for resident #001.

It was observed by Inspector #632 that during meal time resident #001 was not provided eating assistive devices and their Substitute Decision Maker (SDM) was not present.

Review of the written plan of care indicated to provide eating assistive devices with meals as advised by resident and the SDM. Review of the Dietary Card indicated that no eating assistive devices unless the SDM was present. Review of the most recent progress note at the time of inspection indicated that not to provide eating assistive devices to the resident at anytime unless the SDM was present.

During the inspection, the Nurse Manager #1 (NM #1) indicated that the registered staff were to review progress notes and to use the care review form for the documentation of the updates. The resident’s care plan was to be updated accordingly.

Review of Plan of Care Policy stated that the plan of care was a communication tool and was 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 identified needs and resident’s preferences.

The licensee failed to ensure that staff involved in the different aspects of care collaborated with each other in the assessment of resident #001 related to the directions on providing eating assistive devices to the resident, so that their assessments were integrated and were consistent with and complemented each other. [s. 6. (4) (a)]

3. 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. A Complaint Report was submitted to the MOLTC for resident #001.

i. Review of the written plan of care provided directions to staff related to all transfers for resident #001. Review of progress notes and other clinical documentation identified that on an identified date in November 2019 staff did not follow the directions indicated in resident #001's plan of care. The process of documentation was confirmed by PSW #137.

ii. Review of the written plan of care indicated that resident #001 was to be provided dietary interventions during their meals. Progress notes review indicated that the POA expressed a concern about dietary interventions, which were partially provided to resident #001 by staff. During the inspection, PSW #102 indicated that they partially provided dietary interventions expecting that the POA would complete them, since they were present at the time of the providing the interventions. During the inspection, DA #122 indicated that dietary interventions could be done at the servery by DAs or by PSWs, who were available to provide help. During the inspection, the RD was interviewed and indicated that if the resident required dietary interventions it was to be completed at the point of service.

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

The licensee failed to ensure that the care set out in the plan of care related to transfers and dietary interventions was provided as specified in the plan for resident #001.

B. Review of the written plan of care indicated that resident #002 was on identified nutrition protocol, which included dietary intervention during meal times.

It was observed that resident #002 was not provided dietary intervention during the meal time.

During the inspection, PSW #121 indicated that the dietary intervention was not provided due to the change in the resident's continence status. During the inspection, RPN #123 indicated that staff was to inform the registered staff about the change in the resident’s continence status if reassessment in intervention protocol was needed, for which they

were not informed about by staff. Progress notes for an identified period of time in January 2020, did not contain any documentation about change in the resident's continence status.

Review Plan of Care Policy indicated that it was a communication tool and was 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 identified needs and resident's preferences.

The licensee failed to ensure that the care set out in the plan of care related to nutrition care was provided as specified in the plan for resident #002. [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 is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including interventions and the resident's responses to interventions were documented.

A. A Complaint Report was submitted to the MOLTC in relation to the plan of care for resident #001.

Care plan review indicated that resident #001 had interventions in place related to their continence management.

Review of Documentation Survey Report for an identified period from November 2019 to January 2020, indicated that on identified dates continence tasks were not documented.

During the inspection, PSW #132 and PSW #142 indicated that on identified dates from November 2019 to January 2020 the care was provided but was not documented. PSW #106 indicated that on identified dates in November and December 2019, the resident was checked but there was no need to provide interventions and they did not document it.

During the inspection, the DON indicted that any resident's care provided was to be documented at the end of the shift.

Review of the home's Point of Care (POC) Documentation indicated that POC would be competed prior to the end of the shift by the staff that provided the care ensuring that the documentation of resident's required care was completed in POC.

The home failed to ensure that any actions taken with respect to resident #001 under continence program for an identified period from November 2019 to January 2020, including interventions and the resident's responses to interventions, were documented.

B. Care plan review indicated that resident #003 had interventions in place related to their continence management.

Review of Documentation Survey Report for an identified period from December 2019 to January 2020, indicated that there was no documentation in continence task.

During the inspection, PSW #143, who worked on identified dates in December 2019, and in January 2020, was not able to confirm the reason for no documentation.

During the inspection, the DON indicted that any care provided to residents was to be documented at the end of the shift.

Review of the home's POC Documentation indicated that POC would be competed prior to the end of the shift by the staff that provided the care ensuring that the documentation

of resident's required care was completed in POC.

The home failed to ensure that any actions taken with respect to resident #003 for an identified period from December 2019 to January 2020 under continence program, including interventions and the resident's responses to interventions were documented. [s. 30. (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 and ensuring that any actions taken with respect to a resident under a program, including interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

Issued on this 12th day of February, 2020

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

Original report signed by the inspector.