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
Nov 13, 2020	2020_560632_0014	015747-20, 016197-20, 017670-20, 018675-20	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

YULIYA FEDOTOVA (632), LESLEY EDWARDS (506)

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): October 6, 7, 8, 13, 14, 15, 16, 19, 20, 21 (on-site), October 22, 26, 27, 2020 (off-site).

The following Critical Incident System (CIS) inspections were completed:
log #015747-20 - related to falls preventions,
log #016197-20 - related to medications,
log #017670-20 and #018675-20 - related to prevention of abuse and neglect.

Follow Up (FU) Inspection log #018675-20 to Compliance Order (CO) #001 related to s. 19 (1), issued in inspection #2020_845585_0006, was also conducted with this CIS inspection.

Complaint Inspection# 2020_560632_0013 was conducted concurrently with this inspection:
log #019216-20 and #018205-20 - related to abuse and neglect, falls prevention, nutrition and hydration and accommodation services - maintenance.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Nurse Manager #1, Nurse Manager #2, Utility Maintenance Operator, Physiotherapist, Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs).

During the course of the inspection, the inspectors 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:
Critical Incident Response
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation

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

- **3 WN(s)**
- **0 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)	CO #001	2020_845585_0006	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 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 residents were protected from abuse by anyone.

Physical abuse was defined under O. Reg. 79/10 as “the use of physical force by a resident that caused physical injury to another resident’’.

A review of progress notes for resident #003 identified that they physically abused resident #001. The Initial Skin and Wound Assessment of resident #001 indicated altered skin integrity as a result of the incident.

A review of resident #003's and resident #001's care plans indicated that the residents exhibited specified behaviors.

During the inspection, the Administrator acknowledged the incident of physical abuse from resident #003 towards resident #001.

Resident #001 was put at risk of injury as a result of physically abusive behavior exhibited by resident #003.

Sources: progress notes, care plan for resident #003 (date: July 23, 2020), care plan for resident #001 (date: May 21, 2020), Initial Skin and Wound Assessment for resident #001, interview with the Administrator.

The following was further evidence to support the order issued on September 1, 2020, during inspection 2020_845585_0006 to be complied by September 10, 2020. [s. 19. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that where an incident occurred that caused an injury to a resident, for which the resident was taken to the hospital, but the licensee was unable to determine within one business day whether the injury had resulted in a significant change in the resident's health condition, the Director was informed of the incident involving the resident, no later than three business days after the occurrence of the incident, and followed with the report required under subsection.

A review of resident #005's progress notes identified that the resident had a fall on an identified date in July 2020. Two days later, the home was informed about the resident's injury. A review of Critical Incident Report, submitted by the home, indicated that it was initially submitted four days after the incident. Critical Incident Report Policy identified reporting time frame to be within three calendar days.

During the inspection, RN indicated that they verbally received an update on the resident's status and failed to submit the CIS at that time. The Nurse Manager acknowledged that the home did not inform the Director within three business days after the occurrence of the of the incident.

The resident was at increased risk of not having the home's involvement in timely manner into the addressing the change in the resident's health status.

Sources: progress notes, Critical Incident (CI) Report #M592-000055-20, Critical Incident Report Policy No: AM-05-05, interviews with RN #108 and the Nurse Manager #1. [s. 107. (3)]

WN #3: 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 drugs were administered to resident #007 in accordance with the directions for use specified by the prescriber.

A review of a Critical Incident, that was submitted by the home, identified that resident #007 was administered resident #008's medications in error by the RPN.

The RPN gave resident #007 their scheduled medications along with resident #008's medications. Documentation confirmed that the physician was contacted and heightened monitoring was ordered but did not result in any harm to the resident.

Interview with the RPN confirmed that they were distracted by an incident in the specified home area and that resident #007 was given resident #008's medications in error and therefore resident #007 did not receive their medications as prescribed.

Sources: CI Report #M592-000058-20, resident #007's clinical record, medication incident and interview with RPN #115. [s. 131. (2)]

Issued on this 18th day of November, 2020

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

Original report signed by the inspector.