Inspection Reports Summary for Wentworth Lodge

Date of Visit	Report Received	Inspection Trigger	Area(s) of Focus	Compliance Findings
July 24 – Aug 10/20	Aug 31/20	2 Complaints 2 Critical Incidents System Reports (CIS)	Plan of Care	Resident was transferred from bed to a wheelchair which was not supported in the resident care plan. No injuries or negative outcomes. Resident Power of Attorney (POA) has now provided consent for transfers using the mechanical lift.
July 24 - Aug 10/20	Sept 1/20	7 CIS 1 Complaint	Failure to Protect from Abuse, Plan of Care, Reporting Abuse, Responsive Behaviour Program	Resident with dementia and responsive behaviours had an interaction with two other residents that resulted in a bruise and a small skin tear. Resident is known to have responsive behaviours and MLTC indicates staff failed to anticipate or stop the interaction. Plan of care should be more fulsome. A staff person failed to alert a supervisor that a resident with dementia touched the chest of another resident with dementia. No finding of sexual abuse but the issue was not immediately reported to MLTC.