Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: August 15, 2023

Inspection Number: 2023-1326-0002

Inspection Type:
Complaint
Critical Incident

Licensee: Schlegel Villages Inc.

Long Term Care Home and City: The Village of Wentworth Heights, Hamilton

Lead Inspector	**Inspector Digital Signature**
Adiilah Heenaye (740741)	Adiilah H Heenaye Sumser Digitally signed by Adiilah H Heenaye Sumser Date: 2023.09.07 11:14:21 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: July 28, 2023, and August 1-4, 2023.

The following intake was inspected in this Critical Incident (CI) Inspection:
- Intake: #00084915 was related to falls.

The following intakes were completed in this CI Inspection:
- Intake: #00018325 and Intake: #00092195 were related to falls.

The following intake was inspected in this complaint inspection:
- Intake: #00091067 was related to medication management, responsive behaviors, plan of care and falls.

The following **Inspection Protocols** were used during this inspection:

Medication Management
Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports re critical incidents

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

The licensee has failed to inform the Director of a critical incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition within one business day after the occurrence of the incident, and followed by a report of the incident.

Rationale and Summary

A resident sustained a fall and was taken to the hospital with a significant change in their health status.

A critical incident report was first submitted two days after the home became aware that a fall incident resulted in a significant change in the resident's health status.

Sources: Review of the critical incident report; clinical record review of a resident; interview with the Administrator. [740741]

WRITTEN NOTIFICATION: Additional training — direct care staff

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (2) 1.

The licensee has failed to ensure that all staff who provide direct care to residents received annual training in the areas of falls prevention and management and behaviour management.

Rationale and Summary

The home's training records was reviewed for staff related to falls prevention and management, and behaviour management. Not all staff completed the training, and the due date for course completion had passed.

By failing to ensure that all direct care staff were trained on falls prevention and management, and behaviour management, there was a potential risk of staff being unaware of the falls prevention program and responsive behaviour program in the home.

Sources: Interview with the Administrator; Review of the home's training records related to falls prevention and management and behavior management. [740741]