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
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Public Report

Report Issue Date: March 4, 2025
Inspection Number: 2025-1326-0001
Inspection Type: Complaint Critical Incident
Licensee: Schlegel Villages Inc.
Long Term Care Home and City: The Village of Wentworth Heights, Hamilton

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: February 20-21, 24-27, 2025, and March 3-4, 2025.

The following intakes were inspected:

- Intake #00134617/Critical Incident (CI) #2841-000028-24 was related to prevention of abuse and neglect;
- Intake #00135037/CI 2841-000029-24 was related to prevention of abuse and neglect;
- Intake #00134784 was related to a complaint regarding prevention of abuse and neglect, resident care and support services, infection prevention and control;
- Intake #00138281 was related to a complaint regarding resident care and support services.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Right to freedom from abuse and neglect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 4.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to freedom from abuse.

The licensee has failed to ensure that three identified resident's were free from abuse by a staff member of the home. A review of the home's internal investigation notes indicated that during identified personal care routines on an identified date in December 2024, a staff member reached for one of the resident's neck and tried to grab it, slapped the second resident on the leg when getting them dressed, and hit the third resident on their arm following personal care. The residents did not sustain injuries.

Sources: The home's internal investigation notes and Critical Incident System Report, and the residents' clinical records.

WRITTEN NOTIFICATION: Right to quality care and self-determination

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.

Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

The licensee has failed to ensure that a resident was afforded privacy when the washroom and main door to the resident's room remained open during personal care assistance from a Personal Support Worker (PSW) on an identified date in December 2024.

Sources: the home's policy titled AM/HS Care, dated August 08, 2024; interviews with staff; video surveillance.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that the care set out in the plan of care for a resident was provided as specified in their plan. A review of the resident's clinical record showed that they did not receive the appropriate oxygen intake when their oxygen saturation was below ninety percent, and neither did staff contact the physician. This was acknowledged by the home's Director of Care who stated that the resident's physician should have been called when oxygen saturation failed to improve on an identified date in January 2025.

Sources: Resident Medication Administration Records, progress notes and staff

interview.

WRITTEN NOTIFICATION: Documentation

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

A) The licensee has failed to ensure that the provision of oral care for a resident was documented as being provided during morning and evening care on identified dates between November 2024 to February 2025.

Sources: Resident plan of care and documentation records; the home's policy titled AM/HS Care, dated August 08, 2024; interviews with resident and staff.

B) The licensee has failed to ensure that the provision of bathing care for a resident was documented as being completed on dates identified during November 2024 and January 2025.

Sources: Resident plan of care and documentation records; the home's policy titled AM/HS Care, dated August 08, 2024; bathing schedule; interviews with resident and staff.

WRITTEN NOTIFICATION: Duty to protect

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

The licensee has failed to ensure that a resident was protected from emotional and verbal abuse by a staff member when personal care was being provided on a date in December 2024.

Under the Ontario Regulation 246/22 (O.Reg. s. 246/22) s. 2, emotional abuse is defined as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident."

Under O.Reg. s. 246/22, s. 2, verbal abuse is defined as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident."

During care on an identified date in December 2024, a resident requested for help. When staff responded and provided assistance, they did so in a manner that was intimidating, with a raised tone of voice and agitation during care that resulted in the resident feeling confused, emotional, and afraid of injury.

Sources: Interview with resident and staff; the home's investigative notes; surveillance video; Critical Incident Report; the home's Prevention of Abuse and Neglect policy, updated January 15, 2025.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that an alleged incident of physical abuse against identified residents by a staff member was immediately reported to the Director. In accordance with s. 154 (3) of the FLTCA 2021, the licensee is vicariously liable to staff members failing to comply with section 28 (1) 2.

According to the home's internal investigation notes, the staff who witnessed the incident confirmed that they did not inform the home's management team until a day later.

Sources: The home's investigation notes.

WRITTEN NOTIFICATION: General requirements

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 2.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.

The licensee has failed to ensure that, where under the continence care and bowel management program, staff used the specifically ordered supplies appropriate for a resident based on their identified condition.

In accordance with O. Reg 246/22, s. 11 (1) (b), the home was required to comply with their catheter care policy which indicated that catheters would be inserted or changed by the registered team member with a physician's order that specified the size and frequency of change, which did not occur for a resident during the month of January 2025.

The resident had physician orders that specified an identified size of catheter was to be changed at a specified time, however in January 2025, it was changed at different times and with different catheter's than what was ordered.

There were no new physician orders for change to frequency or size of the catheter during the identified dates, and the resident had several instances of incontinence from the catheter site.

Sources: Resident physician orders, progress notes; the home's policy titled Catheter Care, dated March 11, 2024; interviews with staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that a resident was safely transferred from their bed to standing position as per policy and best practice, when a staff member was assisting the resident on a date in December 2024. The staff member felt rushed and did not complete the appropriate steps to ensure a safe transfer from a seated position in bed to standing with an assistive device, and as a result the resident was fearful of injury.

Sources: Interview with staff; the home's Manual Transfers policy, dated August 8, 2024; resident plan of care; the home's internal investigative notes; surveillance video.

WRITTEN NOTIFICATION: Bedtime and rest routines

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 45
Bedtime and rest routines
s. 45. Every licensee of a long-term care home shall ensure that each resident of the home has the resident's desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

The licensee has failed to ensure that the desired rest routine and wake up time for a resident was supported to promote comfort due to identified pain. On a specific date, the resident was told by a staff member that they would get them up at a later time. The resident and staff acknowledged that the resident continues to be awoken at a time that is later than their desired wake time.

Sources: Interview with resident and staff; resident progress notes and plan of care; surveillance video.

WRITTEN NOTIFICATION: Evaluation

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 106 (e)
Evaluation
s. 106. Every licensee of a long-term care home shall ensure,
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared.

The licensee has failed to provide a written record of the abuse and neglect program evaluation, including the dates of when the changes and improvements were implemented. A review of the home's May 2024 annual evaluation document identified the areas of concern that needs improvement, however the home was unable to provide information to support the dates when those changes were made.

Sources: The home's Annual Abuse and Neglect Program Evaluation.

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