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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Hamilton, ON, L8P 4Y7
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Public Report

Report Issue Date: August 27, 2025
Inspection Number: 2025-1326-0004
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: August 19- 20, 25-27, 2025

The following intakes were inspected:

1. Intake: #00152979 - Complaint related to resident care and support services and continence care.
2. Intake: #00153007 - Critical Incident (CI) related to resident care and support services.

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

Resident Care and Support Services
Continence Care

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff. The Director of Nursing Care (DNC) acknowledged that the resident's care plan was not clear and should have included specific interventions. On an indicated date, the resident's care plan was updated to include clear directions of the specific interventions.

Sources: A resident's clinical records, Continence Program Policy, and interviews with staff.

Date Remedy Implemented: August 26, 2025

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 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 staff used safe transferring and positioning techniques when assisting a resident. On an identified date, two staff members did not ensure that the resident was safely positioned when transferred, which resulted in the resident to sustain an injury.

Sources: Video review and interview with staff.