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: October 17, 2023

Inspection Number: 2023-1275-0003

Inspection Type:
Critical Incident

Licensee: DTOC III Long Term Care LP by its general partner, DTOC III Long Term Care MGP (a general partnership), by its partners, DTOC III Long Term Care GP Inc. and Arch Venture Holdings Inc.

Long Term Care Home and City: The Wellington Nursing Home, Hamilton

Lead Inspector	**Inspector Digital Signature**
Erin Denton-O'Neill (740861)	Erin Denton-O`Neill Digitally signed by Erin Denton-O`Neill Date: 2023.10.27 14:38:22 -04'00'

Additional Inspector(s)
none

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 26, 28, 29, 2023 and October 4-6, 10 and 12, 2023.
The inspection occurred offsite on the following date(s): September 27, 2023.

The following intake(s) were inspected:
- Intake: #00002275 – Critical incident (CI) related to improper care of a resident
- Intake: #00002508 – CI related to Improper care of a resident
- Intake: #00003667 – CI related to neglect of a resident
- Intake: #00008558 – CI related to falls prevention

The following intakes were completed in this inspection:
- Intake: #00014416 – CI related to falls prevention

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

Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 24 (1) 1.

The Licensee has failed to immediately report improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

Rationale and Summary
A resident who had a plan of care that indicated that they were not to be left alone on the toilet was left alone on the toilet and fell. A critical incident report (CI) was submitted to the Director two days later as an "Incident that causes an injury to a resident for which the resident is taken to hospital, and which results in a significant change in the resident's health status". A staff confirmed that this incident met the definition of improper care, which is to be reported immediately to the Director. The Assistant Director of Care (ADOC) confirmed that improper care is to be reported to the Director immediately.

Sources: CI report, resident's care plan and progress notes, interviews with a staff and ADOC. [740861]

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

The licensee has failed to ensure that a staff used safe transferring and positioning devices or techniques when assisting a resident.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the

LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 36 under O. Reg. 79/10. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 40 under O. Reg. 246/22.

Rationale and Summary

A) On a day in 2022, a resident was to be toileted and transferred with the assistance of one staff, providing constant supervision. The resident was left alone on the toilet, and this was confirmed by staff. As a result of leaving the resident alone on the toilet they fell and sustained an injury.

Sources: CI report, staff interviews, care plan for resident [740861]

B) On a later date, a resident was transferred using a shower chair and the seatbelt was not applied. This was confirmed by a staff and the ADOC. As a result of not using the seatbelt on the shower chair while transferring the resident, they fell.

Sources: CI report, internal letter, interviews with staff, resident's progress notes [740861]