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: December 2, 2024
Inspection Number: 2024-1275-0004
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 14, 18, 19, 21, 2024

The following intake(s) were inspected:

- Intake: #00117622 - Critical Incident (CI) 2784-000004-24 - related to improper/incompetent treatment of resident by staff. Plan of care related to transfers.
- Intake: #00127507 - Critical Incident (CI) 2784-000006-24 - related to Infection Prevention and Control (IPAC).

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 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 failed to ensure that a resident had a falls prevention intervention in place at all times as per their plan of care.

Rationale and Summary

Physician's orders and the resident's care plan stated that a falls prevention intervention was to be in place for the resident at all times to minimize injury to falls. On an identified date, the resident was observed without the intervention in place as confirmed by staff.

The health and safety of the resident was impacted as the home failed to implement the intervention to prevent injury.

Sources: Resident progress notes, care plan, post fall assessment, physician's orders, Critical Incident Report and interview with staff.

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 failed to ensure that a resident received safe transferring techniques by staff.

Rationale and Summary

The plan of care for the resident indicated that they were to receive an identified level of assistance. On an identified date, the resident sustained a fall. Interview with the home confirmed that staff did not use safe transferring techniques when assisting the resident.

Failing to provide the necessary assistance when transferring the resident increased the risk of injury.

Sources: Resident progress notes, care plan, post fall assessment, Critical Incident Report and interview with staff.

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