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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Original Public Report

Report Issue Date: April 10, 2024	
Inspection Number: 2024-1593-0002	
Inspection Type: Critical Incident	
Licensee: City of Hamilton	
Long Term Care Home and City: Wentworth Lodge, Dundas	
Lead Inspector Cathy Fediash (214)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 2, 3, 2024.

The following intake(s) were inspected:

- Intake: #00111362 -Critical Incident (CI) #M592-000007-24 - related to falls prevention and management.

The following intake was completed in this inspection:

- Intake: #00091180 -CI #M592-000012-23 - related to falls prevention and management.

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

Infection Prevention and Control
Falls Prevention and Management

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 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

a) The licensee has failed to ensure that a resident's plan of care was reviewed and revised when their transfer status changed.

Rationale and Summary

The home submitted a CIS when a resident sustained an incident for which they were transferred to hospital and sustained a significant change to their health status.

An assessment conducted on readmission, identified the resident was to be transferred in a specified manner.

A review of their electronic care plan and confirmation with staff, indicated the plan had not been reviewed and revised to reflect their assessed needs, until seven days

following their readmission.

When the transfer plan of care was not reviewed and revised following the resident's change in their care needs, this had the potential to place the resident and staff at risk of harm by potentially performing a transfer that no longer met the assessed needs of the resident.

Sources: CIS report; a resident's assessments and care plan document and an interview with registered nursing staff.

b) The licensee has failed to ensure that a resident's plan of care was reviewed and revised when their weight bearing status changed.

Rationale and Summary

As indicated above, the home submitted a CIS when a resident sustained an incident for which they were transferred to hospital and sustained a significant change to their health status.

The resident was assessed as having a specified weight bearing status. A review of their electronic care plan identified various degrees of the resident's ability to weight bear, none of which had been based on their most current assessment.

Interviews with staff confirmed the resident's care plan had not been reviewed and revised for at least six days, following their assessment.

When the plan of care was not reviewed and revised following the resident's change in their weight bearing status, this had the potential to place the resident

and staff at risk of harm by potentially performing actions that no longer met the assessed needs or capabilities of the resident.

Sources: CIS report; a resident's progress notes and care plan document and interviews with the PT and registered nursing staff. [214]