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

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| **Report Issue Date:** February 20, 2025 |
| **Inspection Number:** 2025-1593-0002 |
| **Inspection Type:**<br>Critical Incident<br>Follow-up |
| **Licensee:** City of Hamilton |
| **Long Term Care Home and City:** Wentworth Lodge, Dundas |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 10 - 12, 14, 18, & 20, 2025.
The inspection occurred offsite on the following date(s): February 13, 2025.
The following intake(s) were inspected:

- Intake: #00132671 - Follow-up related to housekeeping, laundry and maintenance services.
- Intake: #00133441 - Critical Incident (CI) related to falls prevention and management.
- Intake: #00134024 – CI related to prevention of abuse and neglect.
- Intake: #00136539 - CI related to infection prevention and control.
- Intake: #00138830 - CI related to infection prevention and control.

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1593-0005 related to O. Reg. 246/22, s. 96 (2) (a)

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

Housekeeping, Laundry and Maintenance Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Integration of assessments, care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (4) (a)**
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee failed to ensure that the staff and others involved in the different aspects of a resident's care collaborated with each other in the assessment of the resident so that their assessments were consistent with and complemented each other, related to changes in a resident's status.

**Sources**: Resident's clinical health record, staff interviews.

## WRITTEN NOTIFICATION: Duty to Protect

NC #002 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 abuse by a staff member on a specified date while providing care.

Section 2 of Ontario Regulation 246/22 defines "Emotional abuse" 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.

**Sources:** CI, Investigation package, interview with management.

## WRITTEN NOTIFICATION: Required programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.**
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure the falls prevention and management program was followed for a resident after an unwitnessed fall with injury.

In accordance with Ontario Regulation (O. Reg.) 246/22 s. 11 (1) (b), the licensee was

required to ensure the home had in place a falls prevention and management program and that it was complied with.

**Sources:** resident's clinical health record, staff interviews, Fall Prevention & Injury Program, RC-03-02-01.

## WRITTEN NOTIFICATION: Medication management system

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)**
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee failed to implement their ordering and receiving medications policy for a resident when they did not include the date and time of the order, prescriber's signature, and two Registered Nurse checks, as per policy.

**Sources:** resident's clinical health record, staff interviews, Ordering and Receiving Medications Policy: New Medication Orders.