

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Rapport d'inspection en vertu de  
la Loi de 2007 sur les foyers de  
soins de longue durée**

**Long-Term Care Operations Division  
Long-Term Care Inspections Branch**

**Division des opérations relatives aux  
soins de longue durée  
Inspection de soins de longue durée**

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Feb 8, 2022	2022_943988_0005	021113-21	Critical Incident System

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**Licensee/Titulaire de permis**

Schlegel Villages Inc.  
325 Max Becker Drive Suite. 201 Kitchener ON N2E 4H5

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**Long-Term Care Home/Foyer de soins de longue durée**

The Village of Wentworth Heights  
1620 Upper Wentworth Street Hamilton ON L9B 2W3

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**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

PARMINDER GHUMAN (706988)

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**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): February 1, 2, 3 & 4, 2022.**

**The following intake was completed during this Critical Incident System (CIS) inspection: Log #0021113-21 related to fall with injury.**

**Inspector Debbie Warpula (#577) was present for the duration of this inspection.**

**During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Associate Director of Care (ADOC), General Manager, Kinesiologist, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs) and residents.**

**During the course of the inspection, the inspectors toured the home and completed the IPAC checklist, observed residents and staff interactions, reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.**

**The following Inspection Protocols were used during this inspection:  
Falls Prevention  
Infection Prevention and Control**

**During the course of this inspection, Non-Compliances were issued.**

**1 WN(s)**

**1 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification  VPC – Voluntary Plan of Correction  DR – Director Referral  CO – Compliance Order  WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit  VPC – Plan de redressement volontaire  DR – Aiguillage au directeur  CO – Ordre de conformité  WAO – Ordres : travaux et activités</p>
<p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6.  
Plan of care**

**Specifically failed to comply with the following:**

**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. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident was provided falls mats as per the plan of care.

Resident's plan of care included the use of falls mats when in bed as an intervention to manage the resident's falls.

The resident fell out of their bed and sustained an injury because of the fall. At this time, there were no falls mats beside their bed. PSW confirmed that falls mats were not beside the resident's bed at the time of the fall. According to the home's investigation notes and an interview with RN, they stated that they were not aware of the use of falls mats for the resident. Interviews with DOC and review of the plan of care confirmed that staff failed to follow the resident's plan of care for falls prevention by not applying falls mats when the resident was in bed.

Not having the falls mats beside the bed as per the plan of care may have contributed for the resident sustaining a significant injury.

Sources: Resident's plan of care, the home's investigation notes and interviews with DOC and staff.

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.***

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**Issued on this 10th day of February, 2022**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**