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 25, 2024
Inspection Number: 2024-1275-0003
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 16-18, 21, 2024

Inspection Manager - Kwesi Douglas, was present during this inspection.

The following intake was inspected in this Critical Incident (CI) inspection:

- Intake: #00117372/CI #2784-000003-24 - was related to fall 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 (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 the care set out in the plan of care was provided to the resident as specified in the plan.
Specifically, the licensee failed to ensure that the resident was monitored 1:1 by the staff as per their plan of care.

Rationale and Summary
The resident was assessed as a high fall risk due to their history of several falls. Registered staff assessed the resident on a specified date and implemented the fall intervention of 1:1 monitoring by a staff member.

On a specified date, the registered staff assigned to monitor the resident left the resident unattended. The resident experienced a fall resulting in an injury and was transferred to the hospital. A record review of resident's clinical documents indicated that resident was at high risk of falls before and at the time of the fall incident.

An interview with the registered staff confirmed that when the resident sustained a fall, they were not present with the resident for monitoring as per the plan of care.

The health and safety of the resident were impacted as the home failed to implement the planned care for the resident.

Sources: Resident's clinical records, and an interview with the registered staff.

WRITTEN NOTIFICATION: Compliance with manufacturers' instructions

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The licensee failed to ensure that the staff used a specific device in accordance with the manufacturers' instructions.

Rationale and Summary
The resident was assessed as a high fall risk due to their history of several falls. As a fall management intervention, the resident required the use of a specific device when they were in bed.

During an observation of the resident's room, the device used for the resident as a fall intervention was not in working order. Staff acknowledged during an interview that the device was not in functioning order.

A request for specific device component replacement was made to the registered staff on the same day. The device was noted to be in working order during a follow-up observation that same afternoon.

By not using the device in accordance with the manufacturers' instructions, the risk of falls may not have been properly mitigated for the resident.

Sources: Resident's room observations, manufacturer's instruction record sheet, interviews with the registered and direct care staff.