

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

Public Report

Report Issue Date: December 23, 2025
Inspection Number: 2025-1593-0005
Inspection Type: Critical Incident
Licensee: City of Hamilton
Long Term Care Home and City: Wentworth Lodge, Dundas

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 11 - 12, 15 - 16, 18 - 19, and 23, 2025

The inspection occurred offsite on the following date(s): December 22, 2025

The following intake(s) were inspected:

-Intake: #00161650 - Critical Incident (CI) #M592-000016-25 - Fall Prevention and Management.

-Intake: #00162804 - CI #M592-000017-25 - Infection Prevention and Control.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: General Requirements

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 34 (2)

General requirements

s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the

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

resident's responses to interventions are documented.

The home did not document assessments, reassessments, alternatives trialed, consent, or the resident's response to the use of a resident's personal assistive safety device (PASD).

A review of residents clinical records, plan of care including assessments, progress notes, care plan, and physical chart did not identify any documentation of consent, assessment, alternatives trialed and the resident's response to the use of a PASD.

During an interview with the Director of Care (DOC) the DOC confirmed that alternatives to the use of PASDs were discussed with the care team and would be documented in the residents care plan, unless the resident was a new admission and requested the PASD. DOC confirmed that the resident consented for the use of the PASD themselves, however this was not documented.

Sources: resident observation, resident plan of care, assessments, and interviews with staff.