

Communication Update

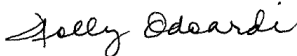
To: Mayor and Members of City Council

Committee Date: July 23, 2026

Subject/Report No.: Ministry of Long-Term Care Inspection

Ward(s) Affected: Ward 13

Submitted By: Holly Odoardi
Director, Long-Term Care & Seniors
Long-Term Care Division
Healthy and Safe Communities Department

Signature: 

The purpose of this Communication Update is to advise Council.

Summary

This Communication Update provides Council with an update on a recent inspection of Wentworth Lodge completed by the Ontario Ministry of Long-Term Care (MLTC) June 2 - 16, 2026, which resulted in one (1) Compliance Order. As per City policy, this order will be submitted to be posted on the City of Hamilton's website.

Background

The Order is related to responsive behaviours. For each resident demonstrating responsive behaviours, the home shall respond to the needs of the resident, including assessments, reassessments and interventions and the resident's response to interventions are documented.

Staff at Wentworth Lodge did not closely monitor two (2) residents who exhibit responsive behaviours. As a result, one resident was able to wander into the other resident's room. This incident resulted in a minor injury to both residents. At the time of the incident, neither of the two residents required one to one staffing.

During the inspection, critical incident investigation notes, the resident's care plans, progress notes, and interviews with staff confirmed the residents were not being closely monitored, which led to one resident wandering into the other resident's room. This placed residents at risk. To mitigate as best possible any further risk, enhanced measures were immediately put in place.

Details

The Order states specifically, the home shall:

- Re-educate all Personal Support Worker (PSW) staff on the specified home area on the responsive behaviours policy and review the identified residents' plan of care, specifically actions and interventions related to responsive behaviours.
- Audit PSW's on the specified home area for two (2) weeks to ensure that the residents' responsive behaviour interventions are carried out.
- Maintain records for all review, education, and training for inspector review, including who completed the audit, the dates the audits were completed, and any actions taken.

Next Steps

The order requires re-education of 69 Personal Support Workers (PSW's). The action plan to re-educate them includes:

- Sign off on required policy: Managing and Accommodating Responsive Behaviours (RC-03-08-01)
- In-person up to 30-minute education sessions for all PSW's on identified home area by July 31, 2026, and complete documentation as evidence education was completed
- Sign off on review of required care plans
- An abbreviated workflow has been created and will be posted for PSW staff to assist when managing residents who exhibit responsive behaviours
- The team has this work underway and will satisfy the Order on or before the due date of August 21, 2026

The Wentworth Lodge staff continue to work closely with MLTC inspectors and remain committed to prioritizing the safety and well-being of each resident and team member. MLTC inspections are a valuable opportunity for long-term care homes to identify opportunities for improvement to programs and services. As such, feedback from the Ministry of Long-Term Care is welcome.

If you have any questions about this communication update, please contact Holly Odoardi at Holly.Odoardi@hamilton.ca or call 905-546-2424 ext. 1906.

Appendices and Schedules Attached

Appendix "A" – Ministry of Long-term Care Inspection Order for Wentworth Lodge, June 16, 2026



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

Public Report

Report Issue Date: June 16, 2026

Inspection Number: 2026-1593-0004

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): June 2-16, 2026

The following intake (s) were inspected:

- Intake: #00170188 - M592-000005-26 - Medication administration.
- Intake: #00173497 - M592-000015-26 - Prevention of abuse and neglect.
- Intake: #00173791 - M592-000017-26 - Falls prevention and management.

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

Medication Management
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS



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COMPLIANCE ORDER CO #001 Responsive behaviours

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

**The inspector is ordering the licensee to comply with a Compliance Order
[FLTCA, 2021, s. 155 (1) (a)]:**

The licensee shall ensure that for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident and interventions in place are implemented.

Specifically, the licensee shall:

1 Re educate all Personal Support Workers (PSW) on the specified unit on the responsive behaviours policy and review the identified residents' plan of care, specifically actions and interventions related to responsive behaviours.

2 Audit PSWs' on the specified unit for two weeks to ensure that the residents'



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responsive behaviours interventions are carried out.

3 Maintain records for all review, education and training for inspector review, including who completed the audit, the dates the audits were completed, and any actions taken.

Grounds

A resident exhibited responsive behaviour and required frequent monitoring to manage and maintain their behaviour.

On a set date, the resident wandered into another resident's room, resulting into both residents sustaining an injury when they were not monitored.

The inaction of staff to ensure that residents were monitored resulted in an injury to both residents.

Sources: CI investigation notes, care plan, progress notes, interview with staff.

This order must be complied with by August 21, 2026



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REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

- (a) the portions of the order or AMP in respect of which the review is requested;
- (b) any submissions that the licensee wishes the Director to consider; and
- (c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3



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Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- (a) registered mail, is deemed to be made on the fifth day after the day of mailing
- (b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
- (c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- (a) An order made by the Director under sections 155 to 159 of the Act.
- (b) An AMP issued by the Director under section 158 of the Act.
- (c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:



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Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
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e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.