Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 6, 2016	2016_519622_0030	024587-16	Critical Incident System

Licensee/Titulaire de permis

DEEM MANAGEMENT LIMITED
2 QUEEN STREET EAST SUITE 1500 TORONTO ON M5C 3G5

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

WELLINGTON HOUSE NURSING HOME
990 EDWARD STREET NORTH P.O. BOX1510 PRESCOTT ON K0E 1T0

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

HEATH HEFFERNAN (622)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 26, 29, 30, 31, 2016

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, the Acting Director of Care, the Regional Director of Extendicare, a Registered Nurse, a Personal Support Worker and the resident.

The inspector also observed staff to resident interaction; reviewed resident health care records; internal investigation files and a critical incident report.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident and resident's Substitute Decision Maker were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

On a specified dated and time, resident #002 received an injury. While staff were assessing the resident, he/she reported that the Personal Support Worker had been rough with him/her causing the injury. On a specified date and time, the home submitted a critical incident of alleged staff to resident abuse to the Ministry of Health and Long Term Care.

On August 26, 2016 at 1240 hours, inspector #622 interviewed the Acting Director of Care #102 who indicated he was not aware if resident #002 or resident #002's Power of Attorney had been notified of the investigation results as he performed the initial investigation. The Acting Director of Care further indicated he handed the results over to the Regional Director of Extendicare #103 who handled the investigation following that.

On August 26, 2016 at 1340 hours, inspector #622 interviewed the Regional Director of Extendicare #103 who indicated she had not notified resident #002 nor resident #002's Power of Attorney of the investigation results, she further indicated she gave instruction to the Acting Director of Care #102 to update the critical incident report to the Ministry of Health and Long Term Care and notify the Substitute Decision Maker of the investigation outcome.

Further interview on August 26, 2016 at 1430 hours with the Acting Director of Care #102 confirmed neither resident #002 nor resident #002's Substitute Decision Maker had been notified of the homes investigation results regarding resident #002's allegation of staff to resident abuse.

On August 29, 2016 at 0927 hours, inspector #622 interviewed resident #002 who indicated he/she had not been informed of the results from the homes investigation regarding his/her allegations of staff to resident abuse. [s. 97. (2)]

Issued on this 6th day of September, 2016

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

Original report signed by the inspector.