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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 11, 2018	2018_554541_0007	005204-18, 010212-18, 010906-18	Complaint

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. Box 1510 PRESCOTT ON K0E 1T0

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

AMBER LAM (541)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 26 and 27, 2018

Three complaints were inspected during this inspection:
One complaint regarding resident care and staffing and an two intakes regarding responsive behaviors

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, a Registered Nurse, Registered Practical Nurses, the RAI Co-ordinator, Personal Support Workers and residents. In addition, the inspector reviewed the staffing plan, resident health care records including bath schedules, and observed resident interactions.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Reporting and Complaints
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **2 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. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan includes a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work (including 24/7 RN coverage).

Related to a complaint:

A complaint was received by the Ministry of Health and Long-Term Care on March 14, 2018 indicating, among other concerns, that the home was working short-staffed and as a result resident's were not getting the care that they needed.

Inspector #541 requested the home's staffing plan from the Director of Care (DOC). Upon review of the staffing plan, there was no documentation to address situations when the home cannot get a Registered Nurse to come to work. During an interview, the Director of Care indicated the home does have a back up plan to ensure the home has an RN on site 24/7 however the backup plan is not documented in the staffing plan. [s. 31. (3)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The home failed to ensure that the Director was immediately informed, in as much detail as possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

5. An outbreak of a reportable communicable disease as defined in the Health Protection and Promotion Act.

Related to a complaint:

A complaint was received by the Ministry of Health and Long-Term Care on a specified date indicating, among other concerns, that the home had 15 residents become ill overnight.

Inspector #541 reviewed the Ministry of Health and Long Term Care Critical Incident System and no report was found notifying the Director of an outbreak.

The home's Director of Care (DOC) indicated the home was in an outbreak on the specified date. An "Outbreak Summary Report" completed by the Health Unit of Leeds, Genville & Lanark District indicated there were 15 resident cases of Influenza A during the outbreak. The Health Unit was notified on the same specified date.

During a conversation with the home's DOC, it was confirmed the home did not notify the Director of the outbreak. [s. 107. (1) 5.]

Issued on this 12th day of July, 2018

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

Original report signed by the inspector.