Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
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347 rue Preston bureau 420
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 28, 2022	2022_627004_0001	011403-21, 017832-21	Critical Incident System

Licensee/Titulaire de permis

Arch Long Term Care LP by its General Partner, Arch Long Term Care MGP, by its partners, Arch Long Term Care GP Inc. and Arch Capital Management Corporation
161 Bay Street Suite 2100 Toronto ON M5J 2S1

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

GURPREET GILL (705004), AMBER LAM (541)

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): January 6, 7, 11 and 12, 2022.

The following intakes were inspected in this Critical Incident System (CIS) inspection:
Log #: 017832-21 (CIS: 2807-000006-21) related to alleged staff to resident verbal abuse.
Log # 011403-21 (CIS: 2807-000004-21) related to a resident fall with injury.

During the course of the inspection, the inspector(s) spoke with the Administrator/ Director of Care (DOC), the Infection Prevention & Control (IPAC) manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), housekeeping staff, activity aide, COVID screener and residents.

During the course of the inspection, the inspector(s) reviewed the resident health care records, licensee policies and other pertinent documents. The Inspector(s) observed residents, resident home areas, the provision of care and services to residents, staff to resident interactions, resident to resident interactions and infection control practices.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **1 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	Légende 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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1.The licensee failed to ensure that a person who had reasonable grounds to suspect the abuse of a resident by staff member #108 had occurred or may occur immediately report the suspicion and the information upon which it was based to the Director.

The following were incidents of alleged abuse and/or neglect involving staff member #108:

In November 2021, the Administrator interviewed a PSW as part of the home's investigation. During that interview, the PSW indicated that staff member #108 was abusive, very intimidating towards the residents and speaking to the residents in a demeaning voice.

On a date in Fall 2021, a resident had wandered into the wrong room. The PSW heard staff member #108 yelling at the resident to stand up and that they could not be in this room and was forcing the resident to stand up. Both staff assisted the resident back to their room. Later that night while completing rounds, the PSW noted an injury to the resident's arm. The PSW mentioned this to staff member #108 who acknowledged that they had caused the injury.

On a day in October 2021, a resident rang their call bell. Staff member #108 answered the bell and yelled at the resident that they didn't have time for the resident and to stop

ringing the bell. Another PSW witnessed the incident and went to assist the resident.

On a date in late September 2021, the PSW witnessed staff member #108 went to a resident's door and shouted at the resident to stop calling out or they will close the door.

On an unknown date, staff member #108 told a resident to stop ringing their call bell. The resident was asking for help and staff member #108 refused to provide help.

On an unknown date during a night shift, a resident voided on floor in the front of the bathroom. Staff member #108 yelled at the resident that they should not be using the bathroom as there are other residents who use this bathroom. The staff member then taped the resident's bathroom door shut and it was left like this until the following morning.

A resident stated that staff member #108 called them names and told them that they did not know what they were talking about. The resident stated that the staff member's comments made them feel bad.

Another resident stated that staff member #108 yells at them to stop ringing the call bell and says they don't have time for them. The resident further stated staff member #108 yelled at another PSW who was trying to help them.

The staff that witnessed the abuse and neglect did not immediately report when the incidents occurred. Failure to immediately report suspected allegations of staff to resident abuse presents risk of harm to the residents.

Sources: Critical Incident report, the home's investigation notes, interviews with the Administrator, an RN and PSWs. [s. 24. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1.The licensee failed to report incidents of alleged abuse to the Substitute Decision-Maker (SDM) of the five residents within 12 hours of becoming aware of the incidents.

During an interview, the Administrator stated that they first suspected resident abuse by a staff member on a day in November 2021. None of the resident's SDMs were notified of the alleged abuse until later that month.

Sources: the home's investigation notes, interview with the Administrator. [s. 97. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's substitute decision-maker are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program, specifically related to assisting residents to perform hand hygiene before and after meals, and also failed to ensure that Personal Support Workers (PSWs) participated in the implementation of the IPAC program related to the use of personal protective equipment (PPE).

Best practice for hand hygiene program indicated that staff should assist residents to perform hand hygiene before and after meals. On a day in January 2022, inspectors observed that residents were not assisted to perform hand hygiene before and after the lunch service.

On a day in January 2022, all residents at the home were identified to be in isolation. All residents were on droplet and contact precautions. Staff were required to wear full PPE when providing direct care. The inspector observed that two PSWs entered a resident's room without gowns to assist the resident with care, who required droplet and contact precautions.

Failing to participate in the implementation of home's IPAC program increases the risk of disease transmission among residents and staff.

Sources: Public Health Ontario-Best Practices for Hand Hygiene in All Health Care Settings, 4th edition (April 2014) and the home's policy -INF 02-01-08 – Infection Prevention and Control practices: COVID-19 Management, 2022/01/14, and observations made by inspectors. [s. 229. (4)]

Issued on this 14th day of February, 2022

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	GURPREET GILL (705004), AMBER LAM (541)
Inspection No. / No de l’inspection :	2022_627004_0001
Log No. / No de registre :	011403-21, 017832-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 28, 2022
Licensee / Titulaire de permis :	Arch Long Term Care LP by its General Partner, Arch Long Term Care MGP, by its partners, Arch Long Term Care GP Inc. and Arch Capital Management Corporation 161 Bay Street, Suite 2100, Toronto, ON, M5J-2S1
LTC Home / Foyer de SLD :	Wellington House Nursing Home 990 Edward Street North, P.O. Box 1510, Prescott, ON, K0E-1T0
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Julie Streska

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To Arch Long Term Care LP by its General Partner, Arch Long Term Care MGP, by its partners, Arch Long Term Care GP Inc. and Arch Capital Management Corporation, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee must be compliant with LTCHA 2007, s. 24.
Specifically, the licensee shall do the following:
1. Provide re-education to three PSWs and any other staff identified by the licensee as requiring education on LTCHA s. 24(1) reporting to the Director.
2. A record of all training provided including the dates and names of persons who attended shall be maintained.

Grounds / Motifs :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect the abuse of a resident by staff member #108 had occurred or may occur immediately report the suspicion and the information upon which it was based to the Director.

The following were incidents of alleged abuse and/or neglect involving staff member #108:

In November 2021, the Administrator interviewed a PSW as part of the home's investigation. During that interview, the PSW indicated that staff member #108 was abusive, very intimidating towards the residents and speaking to the residents in a demeaning voice.

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The staff that witnessed the abuse and neglect did not immediately report when the incidents occurred. Failure to immediately report suspected allegations of

staff to resident abuse presents risk of harm to the residents.

Sources: Critical Incident report, the home's investigation notes, interviews with the Administrator, an RN and PSWs.

The decision to issue a Compliance Order was based on the following:

Severity: There was actual harm to five residents when the incidents between staff member #108 and the residents were not immediately reported.

Scope: The scope of this non-compliance is widespread as five residents were affected.

Compliance History: In the last 36 months, the licensee has had no non-compliance related to LTCHA s. 24.

(541)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

The written request for review must be served personally, by registered mail, commercial courier or by fax 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
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 28th day of January, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Gurpreet Gill

Service Area Office /
Bureau régional de services : Ottawa Service Area Office