Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
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Original Public Report

Report Issue Date: January 26th, 2023	
Inspection Number: 2023-1297-0001	
Inspection Type: Critical Incident System	
Licensee: 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	
Long Term Care Home and City: Wellington House Nursing Home, Prescott	
Lead Inspector Erica McFadyen (740804)	**Inspector Digital Signature**
Additional Inspector(s) Anna Earle (740789)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):

January 18th-20th and 23rd, 2023

The following intake(s) were inspected:

Critical Incident Intake: #00005630/ CI: 2807-000007-22 fall of a resident with injury for which the resident was taken to the hospital and resulted in a significant change in the resident's health condition

Critical Incident Intake: # 00011979/ CI :2807-000010-22 related to improper or incompetent treatment of a resident resulting in harm or risk of harm

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

Resident Care and Support Services

Infection Prevention and Control
Falls Prevention and Management
Reporting and Complaints
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure the infection prevention and control (IPAC) program was complied with regarding the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022". IPAC Standard, section 10.1, requires the licensee to ensure that the hand hygiene program includes access to hand hygiene agents, including 70%-90% alcohol content.

Rationale and Summary

During an observation on January 18, 2023, multiple bottles of Alcohol-Based Hand Rub (ABHR) throughout the home had an alcohol content of 60%, and was being used by both residents and staff to disinfect their hands.

As a result, using an ABHR with an alcohol content of 60%, increases the risk of transmission of infectious agents and the possibility of resulting in illnesses for residents.

Sources:
Direct observations, interview with IPAC Lead #100.
[740789]

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

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The licensee has failed to ensure that when a person has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or risk of harm has occurred or may occur that the suspicion and the information upon which it is based is immediately reported to the Director.

Rationale and Summary

On a specified date, PSW #105 reported to RN #108 that they had witnessed PSW #104 independently complete a transfer using a mechanical lift to transfer resident #001.

During an interview with RN #108 it was stated that not having two PSWs present during a mechanical lift transfer created the potential for risk of harm to resident #001. During an interview with RN #108 it was stated that RN #108 did not contact the manager on call at the time of this incident.

One day later, PSW #105 reported to Administrator #100 that they had witnessed PSW #104 independently complete a mechanical lift transfer for resident #001. Upon receiving this information Administrator #100 commenced an investigation and submitted a CIS report to the Director.

During an interview Administrator #100 stated that the afterhours reporting line was not contacted at the time of the incident, and that there was a delay from when the incident occurred to when the CIS report was submitted to the Director.

Failure to immediately report incidents of resident improper or incompetent care puts residents at risk of additional harm.

Sources:
Interviews with Administrator #100, Director of Care #101, RN #108, and PSW #105

[Inspector ID 740804]