Ontario

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

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: June 16th, 2023	
Inspection Number: 2023-1297-0002	
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** Erica V McFadyen Digitally signed by Erica V McFadyen Date: 2023.06.16 15:08:09 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 13th and 14th, 2023

The following intake(s) were inspected:

- Intake: #00021666/ CIS #2807-000004-23 Resident received incorrect diet texture resulting in a choking incident

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

Food, Nutrition and Hydration
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

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

During record review of the Risk Management report for resident #001 it was noted that on a specified date resident #001, who was assigned a texture modified diet, was served a menu item which contained pieces of solid food. This resulted in resident #001 experiencing a choking episode. In an interview, DOC #100 stated that the incident was discovered while they were reviewing the long-term care homes Risk Management reports and was subsequently submitted to the Director on a specified date one day after the incident.

In an interview with DOC #100 it was stated that the incident should have been reported by the registered staff to the on-call manager at the time it occurred and reported to the Director immediately. DOC #100 confirmed that improper or incompetent care which resulted in risk of harm to a resident was not reported to the Director immediately.

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

Sources
Review of the clinical record for resident #001, interview with DOC #100

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