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 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: January 3, 2024
Inspection Number: 2023-1297-0005
Inspection Type: Critical Incident
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	Inspector Digital Signature
Erica McFadyen (740804)	Erica V McFadyen Digitally signed by Erica V McFadyen Date: 2024.01.04 14:22:16 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 20-22 and 27, 2023

The following intake(s) were inspected:

- Intake: #00101450 - 2807-000010-23 Call bell system not functioning correctly
- Intake: #00102898 - 2807-000011-23 Written complaint about care of a resident
- Intake: #00104141 - 2807-000012-23 staff to resident alleged emotional abuse

- Intake: #00104213 - 2807-000013-23 staff to resident alleged physical abuse
- Intake: #00104217 - 2807-000014-23 staff to resident alleged physical abuse

The following Inspection Protocols were used during this inspection:

Medication Management
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

In accordance with O. Reg 246 / 22 s. 11(1)(b) the licensee is required to ensure their written policy related to Zero Tolerance of Abuse and Neglect is complied with. A Personal Support Worker (PSW) did not comply with the licensee's Zero Tolerance of Resident Abuse and Neglect Policy while providing care to two residents. Specifically, the policy states that "A staff member who is receiving a report of or observing anyone abusing a resident in any manner will... immediately report the abuse as per mandatory reporting".

Rationale and Summary

In an email sent from the PSW to the Director of Care (DOC) it was stated that the PSW witnessed physically and verbally abusive behaviour from a different PSW towards multiple residents during the night shift on a specified date.

In the interview conducted by the DOC with the PSW during the investigation into the alleged abuse, the PSW confirmed that they did not report the alleged abuse of the two residents to anyone until they sent an email to the DOC on a specified date.

In an interview with the DOC it was confirmed that the PSW did not follow the long-term care home's Zero Tolerance for Abuse and Neglect Policy when they failed to report alleged resident abuse immediately.

By not reporting alleged abuse immediately, the PSW put additional residents at risk of sustaining abuse.

Sources

Interview with the DOC, review of email from the PSW, review of the long-term care home's investigation interviews, Zero Tolerance for Resident Abuse and Neglect

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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) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The Licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

Rationale and Summary

On a specified date the DOC received an email from a PSW which stated that a resident had sustained verbal abuse and that additional, unnamed residents had sustained physical abuse. Review of CIS report #2807-000014-23 showed that the alleged abuse was reported to the Director by the DOC one day after the alleged abuse was reported by email. In an interview with the DOC it was confirmed that alleged physical abuse of residents was not reported to the Director immediately.

Failure to report alleged abuse to the Director immediately puts residents at risk of

additional harm.

Sources
Email sent to the DOC, CIS report #2807-000014-23, interview with the DOC

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