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
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Public Report

Report Issue Date: December 10, 2024
Inspection Number: 2024-1297-0003
Inspection Type: Complaint 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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 25, 27, 28, 2024 and December 2, 3, 5, 9, 10, 2024

The following intake(s) were inspected:

- Intake: #00126594-CIR 2807-000018-24 and Intake: #00133285-CIR 2807-000025-24-Covid / ARI Outbreak
- Intake: #00128992-CIR 2807-000019-24-Alleged staff to resident emotional abuse.
- Intake: #00130667-CIR 2807-000021-24-Resident to resident physical abuse.
- Intake: #00131062-CIR 2807-000022-24-Alleged staff to resident emotional abuse and neglect.
- Intake: #00133037-Complaint regarding cleaning of equipment.

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

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.

The licensee has failed to ensure that the home's written Abuse and Neglect Policy was complied with for a resident. A Personal Support Worker (PSW) did not immediately report to the home the allegation of staff to resident emotional abuse and neglect by a Registered Nurse (RN) towards a resident as required in the home's Abuse and Neglect Policy.

Sources: Critical Incident Report, investigation file, Abuse and Neglect Policy and an interview with the Director of Care (DOC).

The licensee has failed to ensure that the home's written Abuse and Neglect Policy was complied with for an incident of resident to resident physical abuse with injury. An RN did not immediately report the incident of resident to resident physical

abuse with injury to the Director as required in the home's Abuse and Neglect Policy.

Sources: Residents' health records, Critical Incident Report, investigation file, Abuse and Neglect Policy and interviews with the DOC and an RN.