

**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

**Public Report**

**Report Issue Date:** November 4, 2025

**Inspection Number:** 2025-1297-0004

**Inspection Type:**

Complaint  
Critical Incident  
Follow up

**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): October 27- 31, 2025, and November 3, 4, 2025.

The following Follow-Up Intake(s) (FUI) were inspected:

- Intake: #00158140 corresponding to Follow-up #1 related to FLTCA, 2021 - s. 28 (1) 2 regarding reporting certain matters to Director.
- Intake: #00158141 corresponding to Follow-up #1 related to FLTCA, 2021 - s. 24 (1) regarding duty to protect.

The following complaint intake(s) were inspected:

- Intake: #00158597 corresponding to a complaint related to alleged emotional abuse of a resident.

The following Critical Incident (CI) intake(s) were inspected:

- Intake: #00158949/2807-000029-25 related to alleged physical/verbal abuse

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of a resident.

-Intake: #00159111/2807-000030-25 related to alleged physical abuse of a resident.

-Intake: #00160611/2807-000034-25 and #00160896/ 2807-000035-25 related to alleged sexual abuse of a resident.

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #002 from Inspection #2025-1297-0003 related to FLTCA, 2021, s. 28 (1) 2.

Order #001 from Inspection #2025-1297-0003 related to FLTCA, 2021, s. 24 (1)

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

Prevention of Abuse and Neglect  
Responsive Behaviours

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

#### **Non-compliance with: FLTCA, 2021, s. 6 (9) 1.**

Plan of care

s. 6 (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.

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The licensee has failed to ensure that the provision of care set out in the plan of care for a resident, specific to hourly safety checks was documented. A review of the October 2025 Point of Care (POC) documentation for the resident identified multiple missing entries on multiple days.

Sources: interview with staff, review of resident's progress notes, and October 2025 POC documentation.

**WRITTEN NOTIFICATION: Reporting certain matters to 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 the the abuse of a resident by anyone that resulted in harm or a risk of harm to the resident was immediately reported to the Director.

Specifically, when an allegation of verbal abuse of a resident was made on a specific date in September 2025, it was not reported to the Director until two days later.

Sources: Resident health records, and interviews with resident and staff.

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## WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)**

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

**1)** The licensee has failed to ensure that when a resident demonstrated responsive behaviours, actions were taken to respond to their needs, including assessment, reassessment and interventions, and resident's responses to interventions were documented.

Specifically, a review of a resident's health records revealed that a Behavioral Supports Ontario – Dementia Observation System (BSO-DOS) was missing numerous entries during a period of behavioural monitoring in September and October 2025.

Sources: Resident health records, and interview with staff.

**2)** The licensee has failed to ensure that when another resident demonstrated responsive behaviours, actions were taken to respond to their needs, including assessment, reassessment and interventions, and resident's responses to interventions were documented.

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Specifically, a review of another resident's health records revealed that a Behavioral Supports Ontario – Dementia Observation System (BSO-DOS) was also missing numerous entries during a period of behavioural monitoring in September and October 2025.

Sources: Resident health records, and interview with staff.

## **WRITTEN NOTIFICATION: Police notification**

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 105**

Police notification

s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

**1)** The licensee has failed to ensure that the appropriate police service was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Specifically, the alleged physical abuse of a resident by another resident that occurred on a date in September 2025, was not reported to Ontario Provincial Police (OPP) until the next day.

Sources: Interview with staff, review of resident health record.

**2)** The licensee has failed to ensure that the appropriate police service was immediately notified of any alleged, suspected or witnessed incident of abuse or

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neglect of a resident that the licensee suspects may constitute a criminal offence.

Specifically, the alleged sexual abuse of a resident by another resident that occurred on a date in October 2025, was not reported to the Ontario Provincial Police (OPP) until four days later.

Sources: Interview with staff, review of resident health record.