Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 1, 2, 8, 9, 11, 14, 15, 29, 2012	2012_044161_0022	Critical Incident

Licensee/Titulaire de permis

DEEM MANAGEMENT LIMITED
2 QUEEN STREET EAST, SUITE 1500, TORONTO, ON, M5C-3G5

Long-Term Care Home/Foyer de soins de longue durée

WELLINGTON HOUSE NURSING HOME
990 EDWARD STREET NORTH, P.O. BOX 1510, PRESCOTT, ON, K0E-1T0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

KATHLEEN SMID (161)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care and the Clinical Co-ordinator.

During the course of the inspection, the inspector(s) reviewed resident health records, home policies related to resident abuse and responsive behaviours and employee S100 disciplinary file.

During the course of the inspection, three Critical Incident inspections were conducted: Log # O-002655-11, # O-000367-12 and # O-000438-12.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry

Infection Prevention and Control

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following subsections:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCH 2007 s. 23 (2) in that the results of their abuse investigation were not reported to the Director.

An incident of staff to resident emotional abuse occurred in December 2011 involving resident # 002 and staff member # S100.

On May 8, 2012 Inspector # 161 asked the Administrator/Director of Care for the results of the home's investigation into the incident of staff to resident abuse that occurred in December 2011. According to the Administrator/Director of Care, the staff member # S100 employment was terminated as a result of the home's investigation into this incident. [Log # O-002655-11].

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following subsections:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 97(1)(a) in that a resident's Substitute Decision Maker (SDM) was not notified within 12 hours upon becoming aware of an incident of abuse of the resident.

An incident of staff to resident emotional abuse occurred in December 2011 involving resident# 002 and staff member # S100.

Later, on the same day, the home informed the Ministry of Health and Long Term Care (Ottawa Service Area Office) by means of the Critical Incident Reporting system.

The following day, Long Term Care Homes Inspector # 103 reviewed the Critical Incident and telephoned the home's Director of Care (DOC) to inquire if the DOC had notified the resident's SDM. The DOC indicated she had not notified the resident's SDM.
[Log # O-002655-11].

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding.
2. An unexpected or sudden death, including a death resulting from an accident or suicide.
3. A resident who is missing for three hours or more.
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 s. 107.(1)(5) by not informing the Director immediately of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

In February 13, 2012 the Brockville Public Health Department declared an enteric outbreak involving 4 residents at the home.

On February 21, 2012 the home informed the Ministry of Health and Long Term Care (Ottawa Service Area Office) by means of the Critical Incident Reporting system. [Log # O-000438-12].

Issued on this 29th day of May, 2012

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Kathleen Smith