Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 25, 2021	2021_826606_0007	022443-20, 025510-20, 025631-20, 000399-21, 001929-21	Critical Incident System

Licensee/Titulaire de permis

Corporation of the County of Wellington
74 Woolwich Street Guelph ON N1H 3T9

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

Wellington Terrace Long-Term Care Home
474 Charles Allan Way Fergus ON N1M 0A1

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

JANET GROUX (606)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 16-19, and 23-25, 2021.

The following Critical Incident (CI) intakes were inspected during the course of this inspection:

Log #001929-21, Log #022443-20, Log #025510-20, Log #025631-20, and Log #000399, related to resident to resident physical abuse.

NOTE: Written Notifications WN) and Voluntary Plans of Corrections (VPC) related to O. Reg. 79/10 s. 50(2)(b)(iii), and 54(b) were identified in a concurrent inspection #2021_826606_0006 (Log # 000427-21) and issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Administrator (AA), Registered Dietitian (RD), Behavioural Support of Ontario (BSO) Lead, Skin and Wound Lead, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Substitute Decision Makers (SDM), and residents.

The Inspector also observed staff and resident interactions, provision of care, infection control practices, reviewed residents' health records, and other relevant documents.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when three residents developed areas of altered skin integrity, they were assessed by a Registered Dietitian (RD).

Three residents were identified with altered skin integrity and were not assessed by the RD. The RD acknowledged that the identified residents were not assessed.

Failing to ensure the residents were assessed by a RD could have resulted in worsening of the residents' areas of altered skin integrity.

Sources: progress notes, and an interview with the RD. [s. 50. (2) (b) (iii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian who is a member of the staff of the home, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents #001, #003 and #005; and residents #003 and #007.

Residents #001 and #003 were identified as having responsive behaviours that in some cases, lead to altercations with other residents.

An altercation occurred between residents #003 and #007 due to resident #003's responsive behaviour which caused an injury to resident #003.

Resident #001 exhibited responsive behaviours which lead to an altercation with resident #003 and #005. Both incidents resulted in a fall and injuries to resident #001.

The interventions in place to manage the responsive behaviours exhibited by residents #001 and #003 were not effective. Steps to prevent residents #001 and #003's responsive behaviours were not taken.

Failing to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between these residents could have resulted in further harm to them.

Sources: progress notes, care plans, observations, and interviews with staff. [s. 54. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents by identifying and implementing interventions, to be implemented voluntarily.

Issued on this 12th day of April, 2021

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

Original report signed by the inspector.