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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8

Original Public Report

Report Issue Date: March 22, 2023

Inspection Number: 2023-1624-0003

Inspection Type:
Critical Incident System

Licensee: Corporation of the County of Wellington

Long Term Care Home and City: Wellington Terrace Long-Term Care Home, Fergus

Lead Inspector	**Inspector Digital Signature**
Janet Groux (606)	Janet Groux Digitally signed by Janet Groux Date: 2023.04.11 16:18:43 -04'00'

Additional Inspector(s)
Amanpreet Kaur Malhi (741128)
Gurvarinder Brar (000687)

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 16-17, 21-24, 2023.

The following intake(s) were inspected:

- Intake #00001198 regarding a significant change in a resident's status.
- Intake #00020187 regarding the home's Fall Prevention and Management Program.
- Intake #00005031 and intake #00006287 related to the home's Residents' Prevention of Abuse and Neglect Program.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure the home's "Resident Abuse and Neglect Policy" was complied with for the resident.

Rationale and Summary:
A Critical Incident (CI) reported an allegation of abuse towards a resident.

The home's "Resident Abuse and Neglect Policy", directed the registered staff to assess the resident involved in an abuse incident to ensure their safety. The resident's clinical records did not identify that an assessment was completed for them.

A Registered Practical Nurse (RPN) was informed by a Personal Support Worker (PSW) student that a PSW was rough with the resident during care. The RPN said they did not complete an assessment for the resident to ensure their safety.

The Director of Care (DOC) said the expectation was for registered staff to complete a head to toe assessment and acknowledged an assessment was not completed for the resident.

Failure to assess the resident placed the resident at risk of harm because it could have caused a delay in in the identification and treatment of possible injuries.

Sources: a CI report, the home's "Resident Abuse and Neglect Policy", a resident's care careplan, and interviews with staff. [000687]

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure a resident was protected from abuse by a PSW.

Rationale and Summary:
Section 2 (1) (a), of the Ontario Regulation 246/22 defines abuse as, "any form of verbal communication of a threatening or intimidating nature or verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

The relatives of a resident reported a PSW was verbally abusive towards the resident for using their call bell. The resident teared up and verbalized being afraid to ring their call bell.

DOC #101 indicated that this was an incident of abuse.

Sources: A CI report, the home's internal investigation notes, a Family Concerns Email, and interviews with an RPN and DOC#101. [741128]

WRITTEN NOTIFICATION: Reporting Certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a suspected neglect of a resident by a PSW was reported immediately to the Director.

A) Rationale and Summary:
During HS care, a PSW witnessed another PSW roughly treat a resident. However, the PSW did not report the incident to the DOC until three days later.

Failure to report the suspected neglect immediately increased the resident's risk of continued harm and prolonged suffering.

Sources: a CI report, the home's Internal Investigation Notes, a Copy of E-mail from a PSW and interview with staff. [741128]

B) Rationale and Summary
The licensee has failed to immediately report an allegation of abuse towards a resident

by a PSW.

The relatives of a resident reported to a PSW that an identified PSW was verbally abusive towards a resident.

During a follow-up call, the family of the resident raised concerns about a PSW's mistreatment of the resident to the DOC.

No CI report for an alleged abuse of the resident was submitted to the Director.

The DOC stated that this was an incident of abuse and needed to be immediately reported to the Director.

Failure to report the allegation of abuse of the resident can potentially delay actions taken by the Director.

Sources: the home's Internal Investigation Notes, a Copy of E-mail re: Family Concerns from an identified date. and interviews with staff. [741128]

C) Rationale and Summary
The licensee has failed to ensure that an allegation of abuse towards a resident by a PSW was immediately reported to the Director.

The incident of alleged abuse was reported nine days later to the Director.

The DOC acknowledged that the incident was not reported immediately to the Director.

Sources: A CI report and staff Interviews. [000687]

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg 246/22, s. 112 (1) 1

The licensee has failed to provide the accurate date of occurrence for the CI report of an alleged neglect of a resident.

Rationale and Summary:
An incident of an alleged neglect from a PSW towards a resident occurred on an identified date, however, the CI report stated the incident occurred on another date.

Sources: a CI report, Copy of E-mail from a PSW re: abuse incident from an identified date, and Interview with staff. [741128]

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure a resident was provided the care as set out in their plan of care.

A) Rationale and Summary:
A PSW witnessed another PSW undress a resident in a manner that did not follow their plan of care despite the resident telling the PSW no during their HS care provision.

The resident's care plan interventions for dressing instructed staff to use a gentle approach when dressing the resident. Staff were to announce themselves prior to entering the resident's personal space, explain all tasks prior to completing the tasks and give space and re-approach the resident as needed.

The PSW said the other PSW should have stopped and re-approached the resident at a later time.

Failure to follow the resident's care plan for dressing put the resident at risk of potential injury and their individualized care needs not being met.

Sources: A CI report, the home's Internal Investigation notes, a resident's plan of care, Copy of E-mail from a PSW re: abuse incident from an identified date, and interviews with staff. [741128]

B) Rationale and Summary:
The licensee has failed to ensure a resident was provided the care as set out in their plan of care.

During an evening care, a PSW witnessed another PSW aggressively pull out an elastic band from a resident's hair without announcing or explaining the task to the resident.

The resident's care plan indicated the requirement for staff to use a gentle approach when assisting the resident with personal hygiene. Staff should announce themselves prior to entering the resident's personal space, explain all tasks prior to completing them, give space and re-approach the resident as needed.

The PSW acknowledged pulling the elastic band out of the resident's hair without introducing themselves and informing the resident of what they were going to do. As a result of the incident, the resident called out in pain.

Sources: A CI report, the home's Internal Investigation notes, a resident's plan of care, Copy of e-mail from a PSW re: abuse concerns from an identified date, and interviews with staff. [741128]

C) Rationale and Summary:
The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

The care plan for the resident said staff were to provide the resident a specific intervention for bathing due to their responsive behaviours.

The resident received a bath in a manner that did not follow their plan of care which resulted in the resident to display responsive behaviours towards the staff. The PSW acknowledged they did not follow the resident's care plan.

The DOC acknowledged that the PSW did not follow the resident's care plan for bathing.

Sources: a resident's care plan and Interviews with staff. [000687]