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
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Waterloo, ON, N2V 1K8
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Original Public Report

Report Issue Date: October 10, 2023

Inspection Number: 2023-1624-0004

Inspection Type:
Critical Incident

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**
Yami Salam (000688)	Yami Salam Digitally signed by Yami Salam Date: 2023.10.12 10:41:11 -04'00'

Additional Inspector(s)
Mark Molina (000684)
Jessica Bertrand (722374) was present during the inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 20-22, 26-29, 2023

The following intake(s) were inspected:
- Intake: #00084440 - Staff to multiple residents abuse.
- Intake: #00087492 - Staff to resident abuse.

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

Resident Care and Support Services
Continence Care
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 3.

The Licensee has failed to ensure that a staff member respected a resident's rights to participate in decision making.

Rational and Summary
A resident became upset when a staff member did not include them in a decision about their care. The Director of Care (DOC) said that the resident's right to make a decision was not respected.

Sources: Home's internal investigation, interview with the resident, PSW, RPN and Director of care. [000688]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that the plan of care was revised when a resident's care needs changed and care set out in the plan was no longer necessary.

Rationale and Summary
A resident's plan of care stated that a specific care routines were a trigger for behaviours; however, it also stated that they were on a scheduled routine for that specific care.

As per interviews with the resident, Registered Nurse (RN) and other staff, the resident was no longer on a scheduled routine. Interview with RN stated that the plan of care should have been updated.

By not updating the plan of care, there was a risk for the resident to receive discontinued interventions.

Sources: Resident's plan of care, progress notes; Interviews with the resident, RN and other staff. [000684]

WRITTEN NOTIFICATION: Duty to Protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was protected from verbal abuse by a staff.

Section 2 (1) (b) of the Ontario Regulation 246/22 defines verbal abuse as any form of verbal communication of a belittling nature or any form of verbal communication of 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.

Rationale and Summary
A resident was attended to by a staff member when they had called for assistance.

The staff member responded to the resident in an inappropriate manner causing the resident to feel intimidated.

Failure of the home to protect the resident from abuse, caused the resident to feel afraid to ask for assistance.

Sources: Resident's clinical records, Interviews with the resident; Interviews with the RCM and other staff; Home's investigation notes. [000684]

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to ensure that when staff had reasonable grounds to suspect that when abuse of a resident by staff occurred, that they immediately reported the suspicion and the information upon which it is based on to the Director. Pursuant to s. 154 (3), the licensee is vicariously liable for staff members failing to comply with subsection 28 (1).

Rationale and Summary
A staff member responded to a resident in a way that made them feel intimidated. It was witnessed and

reported to the Registered Practical Nurse (RPN) but was not immediately reported to the Resident Care Manager (RCM).

The RCM said that they were unaware of the incident until the following day; therefore, the incident was not reported to the Director immediately.

The home's failure to immediately report the abuse of the resident may have delayed the Director in responding to the incident.

Sources: Resident interview; RCM, RPN and other staff interview; Home's investigation notes; CI Report. [000684]

WRITTEN NOTIFICATION: Continence Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (c)

The licensee has failed to ensure that a resident received assistance from staff for care.

Rationale and Summary
When a resident called for assistance, a PSW attended to the resident but did not assist with care because it was outside of their scheduled routine. After twenty minutes, the resident called for assistance again, but they did not receive care for an additional thirty minutes.

The resident's plan of care stated that the resident was to be assisted with care whenever they needed outside of their routine.

Interview with Resident Care Manager (RCM) stated that the resident should have been assisted with care when they initially requested.

Sources: Resident 's plan of care, program sign off sheet, progress notes; Interviews with the resident, RCM and other staff; Home's investigation notes. [000684]

WRITTEN NOTIFICATION: Continence care and bowel management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)

The licensee has failed to ensure that a resident who required care, was provided with sufficient care.

Rationale and Summary
A Registered Practical Nurse (RPN) identified that a resident required the assistance from staff due to their physical limitations.

The resident reported that they felt discomfort since a PSW did not provide adequate care. When another PSW checked, they found that the care was not provided adequately.

Director of Care (DOC) said that there was a lack of proper care for the resident.

Failure to provided adequate care resulted in discomfort in resident and put them at risk of altered skin integrity.

Sources: Resident's medical records, interview with PSW, RPN and Director of care. [000688]

WRITTEN NOTIFICATION: Dining and snack service

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.

The Licensee has failed to ensure a Personal Support Worker used proper feeding techniques to assist a resident with eating.

Rationale and Summary:
A Registered Practical Nurse (RPN) witnessed a PSW not using proper feeding techniques while assisting a resident. They had to intervene.

Staff stated that they follow proper feeding techniques to avoid risk of choking.

Failure to use proper feeding techniques to assist the resident with eating put them at risk of choking.

Sources: Critical incident, interview with PSW, RPN and Director of care. [000688]