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

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Original Public Report

Report Issue Date: August 19, 2024

Inspection Number: 2024-1624-0002

Inspection Type:
Complaint
Critical Incident (CI)

Licensee: Corporation of the County of Wellington

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 31, 2024 and August 1, 6-8, 12-14, 2024

The following intake(s) were inspected:

- Intake: #00115068 - related to concerns alleging improper care of several residents
- Intake: #00116071 - related to infection prevention and control
- Intake: #00119581 - related to falls prevention and management
- Intake: #00122392 - related to an allegation of staff to resident abuse

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
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee failed to ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the *Health Protection and Promotion Act* were followed in the home.

Rationale and Summary

In accordance with the Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings Ministry of Health Effective: April 2024, page 24 states that alcohol-based hand rubs (ABHR) must not be expired.

The Inspector identified 10 bottles of expired ABHR located throughout the home.

When the home's Infection Prevention and Control (IPAC) Lead was made aware of the expired bottles of ABHR, they were removed.

Expired ABHR products may not be as effective at killing bacteria and viruses, increasing the risk of transmitting infectious agents in the home.

Sources: Observations, interview with the IPAC Lead.

Date Remedy Implemented: August 14, 2024

WRITTEN NOTIFICATION: Duty to Protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

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

Ontario Regulations 246/22 section 2 (1) (b) defines emotional abuse as any

threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Rationale and Summary

A PSW was abrupt and frustrated with the actions of a resident and proceeded to rush them with care.

The intimidating remarks and actions of the PSW upset the resident and made them feel like they were in trouble.

Sources: Resident's progress notes, interviews with the resident and staff.

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) 1.
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary

An allegation of improper care was reported to the Director of Care (DOC).

When the home did not immediately report an allegation of improper care to the Director, the Director could not assess and act upon the allegation as they were not aware of it.

Sources: A written allegation, interviews with the DOC and other staff.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard issued by the Director with respect to IPAC was implemented.

In accordance with the IPAC Standard, revised September 2023, section 7.3, (b), the IPAC Lead shall ensure that audits are performed as required.

Specifically, the licensee had failed to ensure that the IPAC Lead had implemented audits, at least quarterly, to confirm that all staff could perform the IPAC skills required of their role.

Rationale and Summary

The IPAC Lead provided the Inspector with the home's IPAC audits from May to August 2024. There was no documentation related to auditing to ensure that all staff can perform IPAC skills required of their role.

The IPAC Lead stated they were not aware of the requirement to ensure all staff can perform IPAC skills required by their role at least quarterly, therefore the home was not currently conducting these audits.

When there failed to be quarterly audits of role-specific IPAC skills, the home was unaware of the IPAC practices being implemented by all staff.

Sources: IPAC Standard (September 2023), interview with the IPAC Lead and other staff.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee shall ensure that on every shift, symptoms indicating the presence of infection in residents were monitored in accordance with any standard or protocol

issued by the Director under subsection (2).

In accordance with the IPAC Standard for Long-Term Care Homes, September 2023, additional requirements section 3.1 directs that the licensee must ensure surveillance actions were taken, specifically to ensure surveillance was performed on every shift, and that the surveillance information was tracked and entered into surveillance database and/or reporting tool.

Rationale and Summary

A registered practical nurse (RPN) stated that resident symptom surveillance was conducted daily by registered staff during medication pass and through resident interactions with PSW's. There was no process in the home for registered staff or PSW's to document that a resident had been monitored on every shift because staff were only required to document once it was determined that a resident was symptomatic.

When there was no process that required staff to document that they had completed resident symptom surveillance on every shift, the documentation required for the analysis related to reducing the incidence of infection and outbreaks in the home, was incomplete.

Sources: Interview with the IPAC Lead and other staff.

WRITTEN NOTIFICATION: Dealing with Complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to

the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee failed to ensure that a written complaint made to the licensee concerning the care of a resident, including alleging risk of harm, was immediately investigated.

Rationale and Summary

The DOC received a written complaint concerning the care of a resident. The complainant alleged that the care provided to a resident placed them at risk of harm.

The written complaint was not investigated.

When the home did not immediately investigate a complaint alleging risk of harm to a resident, it was difficult to substantiate the validity of the allegation and the resident potentially remained at risk of harm.

Sources: Written complaint, interviews with the DOC and other staff.