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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Public Report

Report Issue Date: March 18, 2025

Inspection Number: 2025-1624-0001

Inspection Type:
Critical Incident
Follow up

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): March 11-14 and 17-18, 2025

The following intake(s) were inspected:
-Intake: #00135335 -Follow-up #: 1, CO#1, Inspection #2024-1624-0003
-Intake: #00135337 -Follow-up #: 1, CO#2, Inspection #2024-1624-0003
-Intake: #00135336 -Follow-up #: 1, CO#3, Inspection #2024-1624-0003
-Intake: #00137444 - Related to resident to resident abuse

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1624-0003 related to FLTCA, 2021, s. 24 (1)
Order #003 from Inspection #2024-1624-0003 related to FLTCA, 2021, s. 28 (1) 2.
Order #002 from Inspection #2024-1624-0003 related to FLTCA, 2021, s. 25 (2) (e)

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints

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: FLTCA, 2021, s. 25 (2) (e)
Policy to promote zero tolerance
s. 25 (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;

The licensee failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents contained procedures for investigating alleged, suspected or witnessed abuse and neglect of residents.

The home's policy to promote zero tolerance of abuse and neglect did not include a detailed procedure, nor the steps required for how staff are to conduct an investigation related to abuse and neglect of residents. The Director of Care (DOC)

reviewed and revised the policy to include the home's procedures for investigations on March 17, 2025.

Sources: Policy: Resident Abuse Defining, Preventing, Investigating and Reporting the Abuse, Interview with the DOC.

Date Remedy Implemented: March 17, 2025

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 failed to ensure that a resident was protected from abuse by another resident.

For the purpose of this Act and Regulation, "abuse" means: any non-consensual touching, behaviour or remarks or exploitation directed towards a resident by a person other than a licensee or staff member.

On a specified date, a staff member witnessed a resident act inappropriately towards another resident, which caused them to become upset.

Sources: Incident report, resident progress notes, Policy: Resident Abuse Defining, Preventing, Investigating and Reporting the Abuse, Interviews with Staff.

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. 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,
(b) identifying and implementing interventions.

One-on-one supervision was put in place for a resident to protect other residents from their responsive behaviors. On a specified date, the one-to-one failed to inspect the resident's room before allowing entry, where another resident was already asleep. This failure to check the room resulted in the two residents being unsupervised in the room with the door closed for one hour.

Sources: Resident's care plan and progress notes, Interviews with Staff.