



**Ministry of Health and
Long-Term Care**

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

**Ministère de la Santé et des
Soins de longue durée**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**Long-Term Care Homes Division
Long-Term Care Inspections Branch**

**Division des foyers de soins de
longue durée
Inspection de soins de longue durée**

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Public Copy/Copie du public

Report Date(s) / Date(s) du rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 6, 2016	2016_519622_0029	020131-16/026337- 16/020048-16	Complaint

Licensee/Titulaire de permis

DEEM MANAGEMENT LIMITED
2 QUEEN STREET EAST SUITE 1500 TORONTO ON M5C 3G5

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

WELLINGTON HOUSE NURSING HOME
990 EDWARD STREET NORTH P.O. BOX 1510 PRESCOTT ON K0E 1T0

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

HEATH HEFFERNAN (622)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 26, 29, 30, 31, 2016

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, the Acting Director of Care, Registered Nurses, Personal Support Workers, the resident and a family member.

The inspector also observed resident/resident and staff/resident interaction; reviewed resident health care records, internal investigation documentation, a critical incident report and policies/procedures related to Prevention of Abuse; Falls Prevention and Management; Complaints and Customer Service.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

Falls Prevention

Hospitalization and Change in Condition

Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

1 WN(s)

0 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :



1. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Interview with resident #001's Substitute Decision Maker on August 26, 2016 indicated resident #001's bed rails had been removed without his/her knowledge.

Observation of resident #001's room on August 26, 2016 indicated no bed rails were in place on the bed.

Interview with the Administrator/Director of Care #101 on August 29, 2016 indicated she requested the bed rails be removed due to a memo of potential entrapment risk from Extendicare head office, she confirmed they did not discuss the removal of the bed rails with resident #001 or the Substitute Decision Maker at the time.

Interview with resident #001 on August 30, 2016 confirmed he/she was not consulted when the bed rails were removed.

On August 30, 2016 inspector #622 interviewed the Administrator/Director of Care #101 who indicated after a discussion with resident #001 on a specified date, she had a half bed rail placed on resident #001's bed for positioning purposes.

During interview on August 31, 2016 resident #001 indicated to inspector #622; the new half rail which the home placed on his/her bed has assisted him/her with the positioning he/she required while in bed. [s. 6. (5)]



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Issued on this 6th day of September, 2016

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

Original report signed by the inspector.