



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: Oct 14, 17, 18, 21, 2011; 2011\_054133\_0021; Critical Incident

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the designated lead for housekeeping and laundry services and a member of the housekeeping services department.

During the course of the inspection, the inspector(s) viewed the raised toilet seat involved in the Critical Incident, inspected all resident's bathrooms and reviewed the health care record of one resident.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services  
Specifically failed to comply with the following subsections:**

**s. 15. (2) Every licensee of a long-term care home shall ensure that,**  
**(a) the home, furnishings and equipment are kept clean and sanitary;**  
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and**  
**(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

**Findings/Faits saillants :**

1. Related to s. 15 (2) c:

In June, 2011, a resident fell to the floor as they attempted to raise themselves up off of a raised toilet seat. The resident was transferred to hospital and admitted with an injury. The home's investigation into this incident concluded that the raised toilet seat was installed correctly but that it malfunctioned. The Administrator indicated that the locking mechanism at the front of the toilet seat failed and the flanges at the back of the toilet seat did not fit securely to the toilet rim. The result was that the raised toilet seat lifted off the rim of the toilet and tilted over as the resident used the arms rests for assistance to stand.

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following subsections:**

**s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**

- 1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.**
- 2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.**
- 3. A missing or unaccounted for controlled substance.**
- 4. An injury in respect of which a person is taken to hospital.**
- 5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).**

**Findings/Faits saillants :**



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1. Related to s. 107 (3) 4:

In June, 2011, a resident fell to the floor as they attempted to raise themselves up off of a raised toilet seat that malfunctioned. The resident was transferred to hospital and admitted with an injury.

The Director was notified of this Critical Incident on June 15th 2011, 3 business days after it occurred.

Issued on this 24th day of October, 2011

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

*Jessica Lapensée*