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
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901
centralwestdistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: November 21, 2022	
Inspection Number: 2022-1624-0002	
Inspection Type: Critical Incident System	
Licensee: Corporation of the County of Wellington	
Long Term Care Home and City: Wellington Terrace Long-Term Care Home, Fergus	
Lead Inspector Kristen Owen (741123)	**Inspector Digital Signature** Kristen A Owen Digitally signed by Kristen A Owen Date: 2022.11.21 11:40:51 -05'00'

INSPECTION SUMMARY

The Inspection occurred on the following date(s): November 15-17, 2022.

The following intake(s) were inspected:

- Intake # 00005848, related to a fall of a resident.

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

Falls Prevention and Management
Infection Prevention and Control

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)
FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every Minister's Directive that applies to the long-term care home, the Minister's Directive was complied with.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care (LTC) homes, the licensee was required to ensure that the Ministry of Health COVID-19 Guidance: LTC Homes and Retirement Homes for Public Health Units was followed.

The MOH COVID-19 Guidance: LTC Homes and Retirement Homes for Public Health Units referenced the Public Health Ontario fact sheet, Selection and Placement of Alcohol Based Hand Rub (ABHR) during COVID-19 in LTC and Retirement Homes, which states not to use expired product [ABHR] and to note product expiration date when selecting product.

During the inspection, three pump bottles of ABHR were observed in a Neighbourhood Dining Room with expiry dates of May 11, 2022, and April 23, 2022. A PSW was observed assisting two residents with hand hygiene prior to their meal, using the expired ABHR.

The PSW became aware of the expiry dates, and immediately disposed of the expired ABHR's. The PSW then ensured other staff were aware and using active ABHR in the Dining Room. The residents that had used the expired ABHR were assisted with hand hygiene again, using the active ABHR.

There was no impact and low risk to the residents for infection as there was active ABHR available throughout the home to be used.

Sources: Inspector #741123's observations, interviews with a PSW and the IPAC Lead, Minister's Directive: COVID-19 response measures for LTC homes, effective April 27, 2022, MOH COVID-19 Guidance: LTC Homes and Retirement Homes for Public Health Units, Version 8, dated October 6, 2022, Public Health Ontario: Coronavirus Disease 2019 (COVID-19) Selection and Placement of ABHR during COVID-19 in Long-term Care and Retirement Homes dated November 6, 2020.

Date remedy implemented: November 15, 2022

[741123]

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 49 (1)

In accordance with O. Reg 79/10 s. 8 (1) (b), the licensee was required to ensure the falls prevention and management program, at a minimum, provided strategies to monitor residents, and must be complied with.

Specifically, staff did not comply with the policy "Fall Prevention Management Programme Description" revised May 2022, which stated if a head injury is sustained or suspected, initiate a Head Injury Routine.

A resident had an unwitnessed fall. The day after the fall, bruising was identified to a specified area. No Head Injury Routine was initiated to monitor the resident.

An RPN stated that the bruising would have been considered a sustained or suspected head injury, and therefore, the Head Injury Routine should have been initiated.

By not completing the Head Injury Routine for the resident, there was a risk the resident could have had an unidentified head injury.

Sources: The resident's clinical health records, Falls Prevention Management Programme Description, RS8B-030, Wellington Terrace Centre Wellington, ON, last revised May 2022, and interviews with an RPN.

[741123]