Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: December 23, 2024
Inspection Number: 2024-1624-0003
Inspection Type:
Critical Incident

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): November 19-22, 25-28, 2024 and December 2, 2024

The following intake(s) were inspected:
Intake #00125899 related to a respiratory outbreak.

Intake #00126882, intake #00130261, intake #00131881 and intake #00133329 related to resident to resident abuse.

Intake #00128682 and intake #00130598 related to falls prevention and management.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and 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. 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 the IPAC Lead plans, implements, and tracks the completion of all IPAC training and ensures that audits are performed regularly to ensure that all staff can perform the IPAC skills required of their role. Specifically, the licensee had failed to ensure that the IPAC Lead tracks the completion of the audits to ensure all staff can perform the IPAC skills required of their role.

Rationale and Summary
The IPAC Lead provided the Inspector with the home's IPAC audits from the last quarter. The audits were completed in full, however, the spreadsheet that was being used to track the completion of audits did not indicate which staff the home had

completed an audit on. This made it difficult to identify whether all staff were audited on the relevant IPAC duties of their role.

The IPAC Lead confirmed they did not record which staff the audit was completed on; therefore, they were unable to track which staff had been audited.

By not including staff names on the audits, and not tracking which staff have been audited, the home can not demonstrate that all staff performed the IPAC skills required of their role and they can not identify if there were any IPAC knowledge gaps or patterns among staff.

Sources: IPAC Standard (September, 2023), Interview with IPAC Lead, and IPAC audits.

Date Remedy Implemented: November 25, 2024

WRITTEN NOTIFICATION: Integration of assessments, care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident collaborate with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complement each other.

Rational and Summary
The falls risk assessment for a resident conducted by the nursing staff provided a different outcome than the one conducted by the physiotherapist. Staff were not aware of the physiotherapists assessment and did not know how these assessments were integrated.

According to the resident care manager, there was an overlap and differences between the physiotherapist's and nurse's assessments.

When the falls risk assessments were not integrated with one another and not consistent, this can lead to confusion and potentially inadequate fall prevention measures.

Sources: Clinical record review, interviews with the Physiotherapist and Resident Care Manager.

WRITTEN NOTIFICATION: Required programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that when a resident fell, the appropriate referral was completed as indicated on the post fall huddle.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure

the home's falls prevention and management program was in place, and ensure it was complied with. Specifically, staff did not comply with the licensee's Falls Prevention and Management policy which directed staff to refer a resident to pharmacy when they had two or more falls in one week.

Rationale and Summary
Wellington Terrace's Falls Prevention and Management Program directed staff to use the "Post Fall Huddle" UDA. The post fall huddle directed the registered staff to make a referral to the Pharmacist if the resident had two or more falls in one week.

A resident sustained six falls; three of the falls were in one week. The fall on a specified date resulted in injury for which the resident was taken to the hospital. There were no referrals made to the Pharmacist as documented in the post fall huddle.

The fall lead RN acknowledged that a referral to the pharmacist should have been made as indicated in the post fall huddle.

Failure to follow the home's falls prevention procedures may have increased the resident's fall risk by leaving potential medication-related issues unaddressed.

Sources: Falls Prevention and Management Program, review of fall risk assessment and Post fall huddle, and interviews with RN and other staff.

WRITTEN NOTIFICATION: Behaviours and altercations

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,

(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

The licensee has failed to ensure that procedures and interventions were developed and implemented to assist a resident who was at risk of harm or who was harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Rationale and Summary
A resident was involved in two resident to resident incidents that occurred as a result of their particular responsive behaviour.

Resident to resident incident reports for both incidents stated that the care plan was reviewed; however, no additional interventions were added, and the plan of care for their responsive behaviour had not been updated or revised since late 2022.

The Director of Care stated that interventions were not added after the first two incidents.

Failure to develop and implement procedures and interventions placed the resident at risk of harm and potentially harmful interactions with other residents.

Sources: Record review of resident-to-resident incident report, progress notes, Critical Incident System (CIS) reports, and interviews with staff

WRITTEN NOTIFICATION: Hazardous substances

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97
Hazardous substances
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

The licensee has failed to ensure that all hazardous substances are kept inaccessible to residents at all times.

Rationale and Summary
A housekeeping cart was found unattended in the hallway on the second floor, outside the hairdressing salon. The housekeeper confirmed the cart was to be locked when left unattended.

In another area of the home, a housekeeper informed the Inspector that they were aware hazardous chemicals should be kept locked up. However, the lock on their cart had been broken for several weeks, and although they had reported the issue to the Environmental Services Manager, it had not been repaired. Consequently, they had not been able to lock the cart.

The Environmental Services Manager said there were hazardous chemicals that were stored on the housekeeping carts and they were to be locked at all times when not being used.

Failing to ensure that hazardous substances were always kept inaccessible to residents, could potentially result in harm to a resident.

Sources: Observations, interviews with staff.

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COMPLIANCE ORDER CO #001 Duty to protect

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with FLTCA, 2021, s. 24(1)

The licensee shall:

a) Conduct weekly audits on a specified home area to ensure that the home's zero tolerance of abuse and neglect policy is followed for all incidents of alleged, suspected or witnessed abuse. The audits must include a date, record of the incident, and how consent was obtained or determined. The audit should indicate any deficiencies, and document any follow up actions completed, the name and designation of the person conducting the audit. The audit will be completed for a two month period.

b.) Conduct an internal multidisciplinary team meeting with staff assigned to the specified home area, to discuss the responsive behaviours of the a resident. Minutes of this meeting should be documented, including the date, who was in attendance, what was discussed and actions to be taken.

c.) Develop and implement an individualized plan of care related to the resident's responsive behaviours. Ensure these strategies are clearly documented in the resident plan or care and staff are aware how to implement the identified strategies.

d.) Re-evaluate the outcome of any new interventions that are implemented. Keep a record of the evaluation including who completed it, what was reviewed, whether the interventions were effective and how this was determined.

Grounds

The licensee failed to ensure that two residents were protected from abuse by another resident. Additionally, the licensee failed to ensure that a resident was protected from physical 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.

a) **Rationale and Summary**
Staff witnessed an incident of abuse in the dining room, a resident was upset and asked staff to get the other resident away from them.

The licensee failed to protect a resident from abuse by another resident.

Sources: Critical Incident System (CIS) reports, review of clinical records for residents, interviews with staff.

b) Rationale and Summary
Staff found a resident exhibiting unwanted behaviours towards another co-resident in the TV lounge. Staff stated that the co-resident was physically and emotionally impacted from this incident.

The licensee failed to protect a resident from abuse by another resident which negatively impacted them both physically and emotionally.

Sources: Critical Incident System (CIS) report, clinical records of residents , interviews with staff.

c) Rationale and Summary
The home failed to protect a resident from physical abuse by another resident.

For the purpose of this Act and Regulation "Physical abuse" means, the use of physical force by a resident that causes physical injury to another resident.

A resident was injured after being pushed by another resident.

Failure to protect the resident from abuse by another resident impacted them physically and emotionally.

Sources: Critical Incident System (CIS) report, Clinical record review and interview with staff.

This order must be complied with by March 6, 2025

COMPLIANCE ORDER CO #002 Policy to promote zero tolerance

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee has failed to comply with FLTCA, 2021, s. 25 (2) (e)

The licensee shall:
a) Revise the home's zero tolerance of abuse and neglect policy to include procedures for investigating and in particular, responding, to alleged, suspected or witnessed incidents of abuse of a resident. At minimum, the content must include procedures for assessing a resident's capacity to consent to touching, behaviour or remarks, including providing guidelines or procedures for staff to assist them in determining whether the touching or remarks of the nature of the abuse among residents is consensual or non-consensual. Additionally, there should be a process to document how consent was determined after each incident.

b) Ensure all staff and management team are provided training on the revised zero tolerance for abuse and neglect policy, specifically as it relates to responding to alleged, suspected, or witnessed abuse of a resident. This includes the procedure to determine consent.

c) Records of the training must be kept in the home, including dates of when and how the training was delivered, content of the training, and the names of who participated in the training.

Grounds

The licensee failed to ensure the home's zero tolerance of abuse and neglect policy included procedures for how staff respond to an incident of resident to resident abuse. Specifically, it did not include procedures to determine and document whether both residents consented to the act.

For the purpose of this Act and Regulation, "abuse" means: any non-consensual

touching, behaviour or remarks of a abuse or exploitation directed towards a resident by a person other than a licensee or staff member.

Rationale and Summary
A resident was noted to have specific behaviours.

On a specified date the home left the resident alone in a room with a co-resident. There was no documentation to support that a capacity assessment was done to determine whether the co-resident understood the nature of the act they were consenting to. Staff stated they did not believe the co-resident would be able to appreciate consent to an act, based on the cueing and instructions the resident required to perform activities of daily living.

The Home's policy on zero tolerance of abuse and neglect, specifically as it relates to abuse of a resident, did not have direction on how staff were to determine or confirm consent. The home does not have a process outlined in their policy to determine if residents have the capacity to understand what they are consenting to.

Failure to have a procedure to determine whether a resident can consent to an activity, puts the residents at risk of being exposed to unwanted behaviours.

Sources: Clinical records for residents, interviews with staff, the home's policy titled 'Resident Abuse Defining, Preventing, Investigating and Reporting the Abuse' policy, Critical Incident System (CIS) reports.

This order must be complied with by February 19, 2025

COMPLIANCE ORDER CO #003 Reporting certain matters to Director

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
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:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with FLTCA, 2021, s. 28 (1) 2

The license shall:
a.) Provide education to all Registered Nursing staff and Personal Support Workers on a specified home area on:
1.) The definition of abuse and when it is required to be reported, in accordance with Ontario Regulation 246/22.
2.) The duty to report under section 28 (1) of the Fixing Long-Term Care Act, 2021.
3.) Who staff are to report.

b.) Keep documented records of the education provided, including the education content, the name of the educator, the names of the attendees, and date of the training.

Grounds

The licensee failed to immediately report multiple incidents of alleged abuse by a resident towards multiple co-residents.

Rationale and Summary

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During an on-site inspection a resident's progress notes documented multiple incidents of behaviours towards staff and other residents. There was no documentation indicating if these interactions were consensual. The incidents of alleged and/or suspected abused had not been reported to the Director.

The Director of Care stated that after reviewing the resident's progress notes in more detail these incidents should have been considered abuse and should have been reported to the Director.

Failure to report incidents of alleged abuse to the Director may have impacted the Director's ability to respond in a timely manner and put residents at risk.

Sources: Critical Incident System (CIS) reports, the home's policy titled Resident Abuse Defining, Preventing, Investigating and Reporting the Abuse, resident's progress notes, interviews with staff.

This order must be complied with by February 19, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.