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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: September 14, 2023	
Inspection Number: 2023-1591-0002	
Inspection Type: Critical Incident	
Licensee: The Regional Municipality of Niagara	
Long Term Care Home and City: Upper Canada Lodge, Niagara On The Lake	
Lead Inspector Emily Robins (741074)	**Inspector Digital Signature** Emily C Robins Digitally signed by Emily C Robins Date: 2023.09.21 12:05:09 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: August 21-25, 2023.

The following intakes were inspected:

- Intake #00084281 [Critical Incident (CI): M587-000002-23] related to the Falls Prevention and Management Program.
- Intake #00091785 [CI: M587-000005-23] related to improper/incompetent treatment of a resident.

The following intakes were completed:

- Intake #00013347 [CI: M587-000007-22] and Intake #00084217 [CI: M587-000001-23] related to the Falls Prevention and Management Program.

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that the care set out in the plan of care was provided to a resident as specified in their plan.

Rationale and Summary

A resident's plan of care outlined specific steps that staff were to take prior to transporting and/or assisting the resident in their wheelchair.

On an identified date, a Personal Support Worker (PSW) transported the resident in their wheelchair without first ensuring these specified steps were taken. This PSW admitted that this instruction was in the resident's care plan, which was accessible to them. The resident sustained an injury as a result and indicated that this injury negatively impacted their quality of life.

Sources: Resident's care plan and progress notes, Critical Incident Report (CIR) #M587-000005-23, and interviews with resident and staff [741074].

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee failed to ensure that when a person had reasonable grounds to suspect improper or incompetent care of a resident that resulted in risk of harm to the resident, the suspicion, and the information upon which it was based was immediately reported to the Director.

Rationale and Summary

On an identified date, a PSW transported a resident in their wheelchair without first ensuring that the specified steps outlined in their plan of care were taken. The resident sustained an injury as a result.

The Director of Resident Care (DRC) initiated an investigation the same day they were notified of the

incident. They submitted their findings of improper care to the Director the following day. The Ministry of Long-Term Care (MLTC) after hours phone line was not called.

Sources: CIR #M587-000005-23, resident's progress notes, and interview with DRC [741074].

WRITTEN NOTIFICATION: General Requirements

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee failed to ensure that an assessment of a resident under a program was documented.

Rationale and Summary

On an identified date, a PSW transported a resident in their wheelchair without first ensuring that the specified steps outlined in their plan of care were taken. During transport the resident sustained a potential injury, and the Registered Practical Nurse (RPN) was notified immediately. The RPN assessed the resident; however, this assessment was not documented.

Sources: Resident's progress notes and Electronic Medical Administration Record for March 2023, interview with PSW and Registered Nurse (RN) [741074].