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

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7
Telephone: 1-800-461-7137
HamiltonSAO.moh@ontario.ca

Original Public Report

Report Issue Date May 19, 2022
Inspection Number 2022_1612_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
The Region Municipality of Niagara

Long-Term Care Home and City
The Woodlands of Sunset, Welland Ontario

Lead Inspector
Cathie Robitaille #536

Additional Inspector(s)
Cathy Fediash #214
Yvonne Walton #169

Inspector Digital Signature
Cathie Robitaille
2022.06.02 13:04:55
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INSPECTION SUMMARY

The inspection occurred on the following date(s): April 27, 28, 29, May 2, 3, 5, 6, 9, 10, 11, 12, 2022.

The following intake(s) were inspected:

- Intake #003642-21 (CIS#: M617-000002-21)-related to: Falls Prevention and Management
- Intake #008003-21, and #008196-21- (Complaint)- related to: Prevention of Abuse and Neglect, Responsive Behaviours
- Intake #007176-22, and #007130-22 (Complaint)-related to: Resident Care and Support Services, Medication Management, Prevention of Abuse and Neglect, Responsive Behaviours, Skin and Wound Prevention and Management, Falls Prevention and Management

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Responsive Behaviours

- Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION [RESPONSIVE BEHAVIOURS]

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, r. 53 (4) (b)

The licensee has failed to ensure that resident #001, who demonstrated responsive behaviours of resistance to care, had strategies implemented to respond to these behaviours.

A report submitted by the home indicated the resident had an incident the same day.

An interview with staff and the home's investigative notes, indicated students and staff had attempted to provide care for the resident, who refused the care. Staff and students were instructed to leave the resident and re-attempt care after the resident settled.

Awhile later, a Personal Support Worker (PSW) staff had attempted with the assistance of housekeeping staff to assist the resident to get up from bed. The resident demonstrated responsive behaviours. The PSW staff then requested the housekeeper to get another staff and specified equipment. A student responded and with the PSW staff attempted to assist the resident from their bed, using the equipment. The home's investigative notes indicated the resident demonstrated responsive behaviours towards the student and the staff. It was alleged the PSW staff was then physically abusive toward the resident.

The resident had a history of responsive behaviours and had a plan of care in place that identified strategies how to respond to the resident.

Interview with the Administrator and documentation indicated the PSW staff had been aware the resident had responsive behaviours that could escalate during the provision of care and that while strategies had been developed to respond to the behaviours, the staff member had not implemented these strategies, at this time.

When the strategies in place to respond to the resident's responsive behaviours were not implemented, this may have resulted in the resident becoming upset and agitated and placed themselves and staff at risk for harm.

Sources: Critical incident system (CIS) report; resident's progress notes, care plan, home's investigative notes, interviews with an RPN, and other staff.

Cathy Fediash #214