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: November 30, 2023

Inspection Number: 2023-1118-0003

Inspection Type:
Critical Incident

Licensee: Niagara Health System

Long Term Care Home and City: Niagara Health System, Welland Hospital Site, Extended Care Unit, Welland

Lead Inspector	**Inspector Digital Signature**
Erika Reaman (000764)	Erika Reaman Digitally signed by Erika Reaman Date: 2023.12.22 09:27:41 -05'00'

Additional Inspector(s)
Nishy Francis (740873)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 20, 21, 23, 2023

The following intake(s) were inspected:

- Intake: #00092518- Critical incident (CI) #2607-000012-23 Improper/Incompetent treatment for a resident, plan of care related to reassessment and change in health condition.
- Intake: #00092749-CI #2607-000015-23 - Fall of resident resulting in injury.
- Intake: #00100814-CI #2607-000021-23 - Respiratory Outbreak

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: Reporting

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

The licensee has failed to ensure that the Director was immediately informed, in as much detail as possible in the circumstances of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Rationale and Summary

A Critical Incident (CI) report was submitted on a specific date in November 2023, in relation to a respiratory outbreak. The IPAC lead confirmed a respiratory outbreak was declared by the local Public Health Unit on a specific date in October, 2023. The IPAC lead acknowledged that the incident was not immediately reported to the Director through the after-hours line.

When the Director was not immediately informed there was a risk to residents that

elements of the IPAC program were not being implemented properly.

Sources: Interview with IPAC lead; record review of Critical Incident 2607-000021-0003, email communication between Public Health Unit and the home.
[740873]