



**Inspection Report  
under the Long-Term  
Care Homes Act, 2007**

**Rapport d'inspection  
prévue le Loi de 2007  
les foyers de soins de  
longue durée**

**Ministry of Health and Long-Term Care**  
Health System Accountability and Performance Division  
Performance Improvement and Compliance Branch

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**Ministère de la Santé et des Soins de  
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Division de la responsabilisation et de la performance du  
système de santé  
Direction de l'amélioration de la performance et de la  
conformité

Licensee Copy/Copie du Titulaire  Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
February 9, 2011	2011-165-9610-09feb105706	Critical Incident H-00174

**Licensee/Titulaire**  
  
The Regional Municipality of Niagara  
2201 St.David's Road  
Thorold, ON  
L2V 4T7

**Long-Term Care Home/Foyer de soins de longue durée**  
  
Northland Pointe  
2 Fielden Avenue  
Port Colborne, ON

**Name of Inspector(s)/Nom de l'inspecteur(s)**  
  
Tammy Szymanowski

**Inspection Summary/Sommaire d'inspection**

The purpose of this inspection was to conduct a critical incident inspection.

During the course of the inspection, the inspector spoke with: the resident, the administrator and the director of resident care.

During the course of the inspection, the inspector: reviewed the resident's clinical health record and reviewed policies.

The following Inspection Protocols were used during this inspection: Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN

### NON- COMPLIANCE / (Non-respectés)

**Definitions/Définitions**

**WN** – Written Notifications/Avis écrit  
**VPC** – Voluntary Plan of Correction/Plan de redressement volontaire  
**DR** – Director Referral/Régisseur envoyé  
**CO** – Compliance Order/Ordres de conformité  
**WAO** – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Non-compliance with requirements under the *Long-Term Care Homes Act, 2007* (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)

Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

**WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.19(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.

**Findings:**

1. An identified staff member treated a resident roughly while providing care during the bath.
2. The home's policy for Abuse-Free Long Term Care Environment A01412 identifies rough handling as physical abuse and the home's investigation concluded that the staff member did not follow the home's policy for lift and transfers (N070411) which resulted in rough handling of the resident. The resident experienced pain in their neck, back and left shoulder as a result of the incident.

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**WN #2: The Licensee has failed to comply with O.Reg.79/10 s. 104(1)3v**

In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: (3)Actions taken in response to the incident, including, v)the outcome or current status of the individual or individuals who were involved in the incident.

**Findings:**

1. The report to the Director did not include the outcome or current status of the individuals involved. The home did not inform the Director with the outcome from the resident's assessment at the urgent care centre and the outcome of the home's action related to the staff member involved in the incident.

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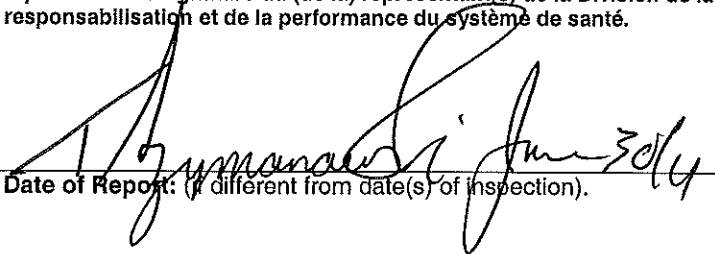
**WN #3: The Licensee has failed to comply with O.Reg.79/10 s.98**

Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

**Findings:**

1. The home did not contact the police immediately to notify them of the suspected physical abuse. It was not until thirty days after the incident occurred and after the inspector visited, that the home reported the incident to the police.

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<b>Signature of Licensee or Representative of Licensee</b> <b>Signature du Titulaire du représentant désigné</b>	<b>Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.</b>
   	
<b>Title:</b>	<b>Date of Report:</b> (if different from date(s) of inspection).