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
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Original Public Report

Report Issue Date: August 9, 2023	
Inspection Number: 2023-1612-0002	
Inspection Type: Critical Incident System	
Licensee: The Regional Municipality of Niagara	
Long Term Care Home and City: The Woodlands of Sunset, Welland	
Lead Inspector Emily Robins (741074)	**Inspector Digital Signature** Emily C Robins Digitally signed by Emily C Robins Date: 2023.08.16 11:23:35 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: July 31, 2023 and August 1-2, 4, 2023.

The following intakes were inspected in this Critical Incident inspection:

- Intake #00016771 Prevention of Abuse and Neglect.
- Intake #00021870 Falls Prevention and Management Program.

The following intakes were completed in this Critical Incident inspection:

- Intake #00005865, Intake #00011963, Intake #00015901 and Intake #00088076 all related to the Falls Prevention and Management Program.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
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 directed the staff to use a specific lift for their transfers to the toilet and to apply “Gentle Persuasive Approaches” when they demonstrated responsive behaviours.

On a specified date in December 2022, two Personal Support Workers (PSWs) provided personal care to this resident related to toileting. During care, they transferred the resident using a type of lift that was different than what was specified in their plan of care and, when the resident demonstrated behaviours during care, one of the PSWs did not utilize the “Gentle Persuasive Approaches” outlined in the plan of care.

Sources: Critical Incident Report (CIR) #M617-000019-22, interview with PSW, resident’s care plan, the home’s investigation notes related to CIR #M617-000019-22 and interview with DRC [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) 2.

The licensee failed to ensure that when a staff had reasonable grounds to suspect abuse of a resident that resulted in potential harm to the resident, the suspicion, and the information upon which it was based was reported to the Director immediately.

Rationale and Summary

A staff alleged that on a specified date in December 2022 another staff was verbally and physically abusive towards a resident while providing care. The concerned staff did not report the alleged verbal

and physical abuse until the following day via e-mail, which was not received until two days following the alleged date of the abuse.

The Director of Resident Care (DRC) indicated that the concerned staff should have reported the incident to the Registered Nurse in Charge (RN) immediately, and that the Director was not notified of the critical incident until two days following the alleged date of the abuse.

Sources: Critical Incident Report (CIR) #M617-000019-22, Long-Term Care After Hours Report #IL-08593-AH, the home's investigation notes related to CIR #M617-000019-22 and interview with the DRC [741074].