Ontario

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

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

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7

Telephone: 905-546-8294
Facsimile: 905-546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
Hamilton ON L8P 4Y7

Téléphone: 905-546-8294
Télécopieur: 905-546-8255

☐ **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.

Inspector ID #:	165

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**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.**
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).