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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Public Report

Report Issue Date: May 14, 2025

Inspection Number: 2025-1605-0003

Inspection Type:
Proactive Compliance Inspection

Licensee: The Regional Municipality of Niagara

Long Term Care Home and City: Northland Pointe, Port Colborne

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 29-30, 2025 and May 1-2, 5-9, 13-14, 2025

The following intake(s) were inspected:

- Intake: #00145896 -Proactive Compliance Inspection (PCI) for Northland Pointe

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Residents' and Family Councils
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Quality Improvement

Residents' Rights and Choices
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Home to be safe, secure environment

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

Non-compliance with: FLTCA, 2021, s. 5

Home to be safe, secure environment

s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee has failed to ensure that the main lobby elevator shaft was safe and secure during maintenance.

On a specified date, inspector observed the elevators in the main lobby on two separate occasions. During observations the door on the right elevator was observed to be open with no barricades or signage in place to prevent a person from entering, which General Maintenance staff indicated was required. A contractor was observed inside of the elevator shaft and the elevator was observed to be below ground level. At the time of observations, there was only one resident in the area.

A staff was present during observation and they indicated the door was open enough for a person to enter and that there was a risk to resident safety. When the home was made aware of the incident they acted immediately.

Sources: Elevator Safety- Maintenance Procedures policy; email with elevator company; contractor sign-in book; interviews with staff and General Maintenance

staff; observations of elevators.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect was complied with when an incident of alleged abuse was reported by a resident to staff on a specified date. Staff did not follow the home's Abuse and Neglect- Zero Tolerance policy when they did not document the incident and did not report the incident directly to the registered nurse which resulted in the on-call manager not being notified and the long-term care after-hours line not being called to report the incident.

Sources: Abuse and Neglect- Zero Tolerance policy; Mandatory Reporting and Critical Incidents Reporting Requirements policy; resident's plan of care; MLTC long-term care home portal; investigation notes; interviews with DORC and staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that an incident of alleged abuse of a resident was immediately reported to the Director.

On a specified date, the Director of Resident Care (DORC) was made aware of an incident of alleged abuse that occurred between two residents. A Critical Incident Report (CIS) was not submitted to the Director following the incident.

Sources: MLTC Long-Term Care Home Portal; Abuse and Neglect- Zero Tolerance policy; Mandatory Reporting and Critical Incidents Reporting Requirements policy; resident's plan of care; interview with DORC.

WRITTEN NOTIFICATION: Safe storage of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that drugs stored in the medication cart were secured and locked.

On a specified date, a medication cart was observed to be unlocked in a resident common area. Residents were present at the time of observation. A Registered staff was observed leaving the medication cart unattended and out of sight.

Sources: Care Rx Medication Pass Audit Tool; Medication Management System policy; observations; interview with Registered staff.