Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Dec 13, 2011	2011_072120_0050	Critical Incident

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD, THOROLD, ON, L2V-4T7

Long-Term Care Home/Foyer de soins de longue durée

UPPER CANADA LODGE
272 WELLINGTON STREET, P. O. BOX 1390, NIAGARA-ON-THE-LAKE, ON, L0S-1J0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator and Director of Care regarding a critical incident related to Resident Abuse and Personal Support Services.(H-002239-11)

During the course of the inspection, the inspector(s) reviewed the home's investigative notes, the home's policies and procedures on abuse and residents' rights, staff educational attendance records and witness statements.

The following Inspection Protocols were used during this inspection:

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The care set out in the plan of care for an identified resident was not provided on an identified day in 2011. An identified personal service worker (PSW) did not follow the plan of care as required for proper assistance during transfers from one position to another.

The first incident occurred when the resident was not given the opportunity to attempt all movements by themselves before being offered assistance, as specified in their plan of care. The PSW told the resident to get ready for bed while they were engaged in another activity. The PSW then proceeded to grab both of the resident's wrists and pulled them up and out of their chair. Another worker witnessed the incident and intervened.

The second incident occurred later on the same day. The plan of care indicates that the resident requires two staff be present during toileting as some weight bearing assistance may be required. The same PSW attempted to toilet the resident independently. The resident was resistive to the care and the PSW used force to position the resident which resulted in the resident becoming agitated. Another worker witnessed the incident and intervened.

The management of the home took immediate follow-up action.

Issued on this 23rd **day of January, 2012**

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs