Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 8, 2015	2015_214146_0018	H-002446-15	Resident Quality Inspection

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

LINHAVEN
403 Ontario Street St. Catharines ON L2N 1L5

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

BARBARA NAYKALYK-HUNT (146), IRENE SCHMIDT (510a)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 21, 22, 23, 26, 27, 28, 29, 30, November 3, 4, 5, 6, 9, 10, 12, 13, 16, 2015

This RQI inspection was conducted concurrently with: Follow up inspection #008046-15 related to resident rights; Complaint inspections #001582-14, #008897-14, #012597-15, #023850-15, #026428-15 related to resident personal care and continence care, falls and food service; and Critical Incident inspections #000371-14, #000079-15, #000883-15, #002023-15, #002238-15, #002263-15, #003661-15, #004183-15, #004507-15, #004755-15, #005310-15, #007060-15, #026055-15 related to alleged abuse, falls, improper care, elopement and responsive behaviours. Findings from all the above inspections are found in this report.
During the course of this inspection, inspectors: toured the home; reviewed resident health records, meeting minutes, policies and procedures, internal investigation notes, the home's complaint log and observed dining service and resident care.

During the course of the inspection, the inspector(s) spoke with the Administrator; Directors of Care (DOC); Associate Directors of Care (ADOC); Food Service Manager (FSM); Resident Assessment Instrument (RAI) coordinator; Recreation manager; registered staff; Personal Support Workers (PSW's); dietary staff; environmental staff; residents and family members.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
10 WN(s)
4 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2015_267528_0006	146

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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:

s. 6. (5) The licensee shall ensure that the resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident’s plan of care. 2007, c. 8, s. 6 (5).

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 :

1. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #405 was transferred to a different unit within the home on a date in April 2015. The resident's Substitute Decision Maker (SDM) was not notified or consulted about the transfer and change in the plan of care. This information was confirmed by the SDM, the health record, the home's internal complaint log and the DOC. [s. 6. (5)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) The care plan for resident #205 specified that a specific intervention would be completed before and after meals and as necessary. On a date in January 2015, staff reported that resident #205 had not received the specified intervention. During the home's investigation, an identified staff member confirmed that the care had not been provided as directed in the preceding six to eight hours. In this instance, care was not provided to the resident as specified in the plan of care. This information was confirmed by the DOC and the home's internal investigation notes.

B) The care plan for resident #205 specified that the resident required extensive assistance during a specific activity. An identified staff member who provided care on a date in January 2015 confirmed that they did not engage the assistance of a second staff person as the care plan specified. This information was confirmed by the DOC.

C) On a date in March 2015, resident #209 sustained an unwitnessed fall with injury. The written plan of care specified that resident #209 should not be left unattended during the specific activity. The health record indicated that staff left the resident unattended during the specific activity. When staff returned, the resident was found on the floor. Care set out in the plan of care was not provided to the resident as specified. This was confirmed by the health record and the DOC. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

Resident #420's admission Minimum Data Set (MDS) assessment indicated that the resident was continent of both bladder and bowel. The next MDS assessment on completed four months later indicated that the resident was incontinent of both bladder and bowel. There were no assessments completed that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. The resident continued to be incontinent and interventions addressed containment only. This information was confirmed by the health record, DOC and the RAI coordinators. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that (a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident requires, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident were identified, where possible; (b) strategies were developed and implemented to respond to these behaviours, where possible; and (c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A) Resident #405's progress notes indicated that the resident had frequent responsive behaviours in March and April 2015. In April 2015 the resident was transferred to a different unit because of these behaviours. A review of the health record and plan of care indicated that strategies were not developed or implemented to manage these behaviours until July 2015. This information was confirmed by the health record, the RAI coordinator and the DOC. [s. 53. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible; (b) strategies are developed and implemented to respond to these behaviours, where possible; and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

s. 111. (1) Every licensee of a long-term care home shall ensure that a PASD used under section 33 of the Act to assist a resident with a routine activity of living is removed as soon as it is no longer required to provide such assistance, unless the resident requests that it be retained. O. Reg. 79/10, s. 111. (1).

s. 111. (2) Every licensee shall ensure that a PASD used under section 33 of the Act,
(a) is well maintained; O. Reg. 79/10, s. 111. (2).
(b) is applied by staff in accordance with any manufacturer's instructions; and O. Reg. 79/10, s. 111 (2).
(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 111 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a PASD used under section 33 of the Act to assist a resident with a routine activity of living was removed as soon as it was no longer required to provide such assistance, unless the resident requests that it be retained.

Resident #205's care plan directed that the resident would use a specific PASD during specific activities and the PASD would be removed once the activity was complete. On a date in January 2015, staff reported that the PASD was applied for the specific activity but it was not removed when the resident completed the activity, as confirmed by the DOC. [s. 111. (1)]

2. The licensee has failed to ensure that the PASD used under section 33 of the Act: was applied by staff in accordance with the manufacturer's instructions.

On a date in October 2015, resident #002 was observed by the inspector to be sitting in a wheelchair with a PASD in place. The PASD was not applied according to manufacturer's instructions The Occupational Therapist (OT) was present and confirmed that the personal assistance services device (PASD) was not applied in accordance with the manufacturer's instructions. [s. 111. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a PASD used under section 33 of the Act to assist a resident with a routine activity of living is removed as soon as it is no longer required to provide such assistance, unless the resident requests that it be retained, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) is complied with.

The home's policy related to the storage and destruction of discontinued narcotics and controlled medications in the Pharmacy Policy and Procedure Manual, Policy 5-4 entitled "Drug Destruction and Disposal" instructs staff to "retain the medications in a double-locked area within the home, separate from those medications available for administration to a resident".

On a date in October 2015, the discontinued narcotics were observed to be in a locked medication room and in a cupboard which was also locked but with a mail slot through which the inspector retrieved a package of hydromorphone tablets by slipping a hand into the mail slot. The package was easily removed from the cupboard through the mail slot even though the door remained locked. In this instance, the narcotics for destruction were under a single lock, as confirmed by the RN in attendance and later, the Administrator. [s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

On a date in March 2015, a resident reported that a PSW was transferring the resident via wheelchair and the resident's bodypart struck the wall. Internal investigation notes indicated that the PSW confirmed the incident occurred as reported by resident #208, In this instance, the staff failed to use safe wheelchair transferring technique. The DOC confirmed this information. [s. 36.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A) Resident #520 sustained a fall in August 2015. There was no post fall assessment completed using the home's post fall assessment tool. This information was confirmed by the health record and the DOC. [s. 49. (2)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that concerns or recommendations under either paragraph 8 or 9 of subsection (1), were responded to, in writing, within 10 days of receiving the advice from Family Council.

The Family Council President reported that Family Council did not receive responses in writing within ten days to concerns raised at Family Council. Review of Family Council minutes revealed that: at the meeting of November 12, 2014, a member recommended more cleaning of railings and also advised that wheelchairs were again blocking a fire exit on the Secord unit; and the meeting minutes of May 13, 2015 and September 9, 2015 indicated that a member reported daily fecal and urine odours in one of the Secord hallways due to unsealed containers.
The Administrator confirmed that the current process with Family Council does not provide the Administrator with the minutes and that written responses to these recommendations and concerns were not provided in writing within ten days. [s. 60. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. An injury in respect of which a person was taken to hospital and that resulted in a significant change in the resident's health condition.

Resident #207 had an unwitnessed fall in December 2014 after which the resident was transferred to hospital. The progress notes indicated that a change in the plan of care was necessary as a result in a change in the resident's health condition. Review of the care plan indicated it was updated to include new strategies as a result of the fall. As confirmed with the DOC, the Director was not informed of this incident that resulted in a significant change in the resident's health condition. [s. 107. (3) 4.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following immunization and screening measures were in place: 1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident had already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

Resident #405 was admitted to the home and did not have a chest X-ray for tuberculosis screening ordered and completed until three months later. Resident #202 was admitted to the home and chest x-ray for TB screening was not ordered and completed until six weeks later. Resident #201 and resident #202 were not screened for tuberculosis within 14 days of admission as confirmed by registered staff, the health record and the DOC. [s. 229. (10) 1.]

Issued on this 8th day of December, 2015

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

Original report signed by the inspector.