Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 14, 2018	2018_661683_0012	012358-18	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Niagara
2201 St. David's Road P.O. Box 344 THOROLD ON L2V 3Z3

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

LISA BOS (683)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 8 and 11, 2018

The following intake was completed during the critical incident inspection:
Log #012358-18, CIS #M551-000021-18 - related to nutrition and hydration.

During the course of the inspection, the inspector(s) spoke with the Administrator, Associate Director of Resident Care, Dietary Manager, Registered Dietitian, Registered Staff, Personal Support Workers (PSW) and residents.

During the course of the inspection, the Inspector toured the home, reviewed resident clinical records, policies and procedures and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

The licensee failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A) A review of critical incident report #012358-18 and staff interviews identified that on an identified date, at an identified time of day, Registered Practical Nurse (RPN) #103 noticed a change in resident #001's health status. RPN #103 responded to the situation, alerted the appropriate staff members and called 911. The resident was transferred to hospital as a result of their change in health status.

A review of resident #001's written plan of care identified specific interventions for the provision of care related to identified health risks. In an interview with staff #101 on an identified date, they indicated that they were aware of the resident's health risks and the interventions in place for them. They indicated that they followed the resident's written plan of care on the identified date, at the identified time of day.

In an interview with PSW #102, they indicated that they had been working nearby resident #001 on the identified date, at the identified time of day, and that the resident's written plan of care was followed.

On an identified date, staff #101 and #102 were interviewed and identified the way in which they interpreted one of the identified interventions in resident #001's written plan of care. The interpretations of staff #101 and #102 were consistent with each other. They identified that they had consistently followed the written plan of care in the identified manner for the resident.

Staff #110, #111 and #112 were asked, separately, what they would do if a resident's written plan of care identified a specific intervention. They all indicated an identified manner in which they would approach the specific intervention, which was different than the way that staff #101 and #102 interpreted the identified intervention.

In an interview with staff #107 on an identified date, they indicated the way in which they interpreted the identified intervention, which was consistent with the way that staff #110, #111 and #122 interpreted the identified intervention.

The home did not ensure that resident #001's written plan of care set out clear directions to staff related to an identified intervention.

B) A review of resident #002's written plan of care identified specific interventions for the provision of care related to positioning and monitoring.

On an identified date, resident #002 was observed in an identified position during the provision of care by PSW #115. RPN #114 was asked by the Inspector how resident #002 was supposed to be positioned during the identified care. They indicated that the resident was to be positioned in a specific manner, which was consistent with the way in which the resident was observed by the Inspector. When the Inspector asked if resident #002's written plan of care identified the specific positioning, RPN #114 indicated that their written plan of care did not identify positioning for when the identified care was provided to the resident. They indicated that the written plan of care identified a specific position, but added that they positioned the resident in a different way for safety.

In an interview with staff #107 on an identified date, they acknowledged that resident #002's written plan of care did not specify their positioning while the identified care was being provided. Additionally, staff #107 acknowledged that resident #002's written plan of care did not specify the level of monitoring required while the identified care was being provided.

The home did not ensure that resident #002's written plan of care set out clear directions to staff related to their positioning and the level of monitoring required while the identified care was provided.

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

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Issued on this 14th day of June, 2018

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

Original report signed by the inspector.