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 Rapport	Inspection No / No de l’inspection	Log # / No de registre	Type of Inspection / Genre d’inspection
Aug 8, 2019	2019_546750_0008	002449-18, 017146-18, 005704-19, 013753-19, 014360-19, 014675-19	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Niagara
1815 Sir Isaac Brock Way 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

STACEY GUTHRIE (750), AILEEN GRABA (682)

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): July 22, 23, 24, 25, 26, 29, 30, 31, and August 1, 2, 2019.

The following intakes were completed in this Critical Incident System Inspection:
017146-18 related to medication;
005704-19, 013753-19, 014360-19, and 014675-19 all related to fall prevention.
This Critical Incident System inspection was completed concurrently with Complaint inspection #2019_546750_0007.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Associate Directors of Resident Care (ADRC), Manager of Long Term Care Behavioural Support (MLTCBS), Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), and Personal Support Workers (PSW).

During the course of the inspection, the inspector (s) observed the provision of resident care and reviewed clinical health records, investigation notes, staffing schedules, meeting minutes, policies and procedures and Critical Incident System (CIS) submissions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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	Légende 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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to resident #007 in accordance with the directions for use specified by the prescriber.

A review of a Critical Incident (CI) identified that a controlled substance for resident # 007 was missing. An internal audit and investigation was completed and the home could not locate the missing medication; the card and missing dose were not found.

The electronic medication administration record (eMAR) for a specified time, was reviewed and included an order for an identified medication for resident #007. On a specified date at an identified time, the ordered medication had the number "10" in the documentation box with Registered Practical Nurse (RPN) #128's initials, indicating "drug not available".

In an interview with RPN #128, they confirmed that they did not administer the medication as ordered, on the specified date at the identified time, as the medication was not available. They also noted that they did not administered the medication through an alternate route to resident #007 as noted on the incident report.

There were no reports of any negative effects to the resident noted in the resident's progress notes on specified dates.

The home failed to ensure that drugs were administered to resident #007 as ordered by the physician. [s. 131. (2)]

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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #2: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participate in the implementation of the hand hygiene program.

On a specified date, inspector #750 observed a medication pass, which included medication administration. During the observation, Registered Practical Nurse (RPN) #113 did not complete hand hygiene between each resident's medication administration.

A review of the home's policy #IC04-002, titled "Infection Prevention and Control: Preventative Measures: Hand Hygiene", dated 07/25/2017, identified the Four Moments of Hand Hygiene, including but not limited to, before initial patient/patient environment contact and after patient/patient environment contact.

During a discussion with the Associate Director of Resident Care (ADRC), they acknowledged that staff should be washing their hands between residents while administering medication.

Home failed to ensure that staff participated in the hand hygiene program while administering medication. [s. 229. (4)]

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 all staff participate in the implementation of the hand hygiene program, to be implemented voluntarily.

WN #3: 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):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of a missing or unaccounted for controlled substance in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4).

A review of Critical Incident (CI) identified that a controlled substance for resident #007 was missing. The Registered Nurse (RN) on duty at the time of the discovery notified the manager on call and completed a full search of the medication cart including the garbage's. An internal investigation began on a specified date, which included the Associated Director of Resident Care (ADRC) at the time completing a search of the med cart and the garbage's on the unit. It was thought that the card may have been thrown out, as it would have had one dose remaining in the card. All staff involved were interviewed, one interview could not be scheduled until an identified date. After staff interviews were completed, it was determined that no staff could guarantee if the card was thrown out. On a specified date, the home identified it as a missing controlled substance and reported it to the Director 16 days later.

In an interview with Administrator #122, they acknowledged that the home's expectation is that a missing controlled substance would be reported to the Director on the date it was reported missing.

The home failed to ensure that the Director was informed of a missing or unaccounted for controlled substance, no later than one business day after the occurrence of the incident on June 13, 2018. [s. 107. (3) 3.]

Issued on this 20th day of August, 2019

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

Original report signed by the inspector.