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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Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: September 6, 2023	
Inspection Number: 2023-1567-0003	
Inspection Type: Critical Incident	
Licensee: The Regional Municipality of Niagara	
Long Term Care Home and City: Linhaven, St Catherines	
Lead Inspector Stephanie Smith (740738)	**Inspector Digital Signature** Stephanie D Smith Digitally signed by Stephanie D Smith Date: 2023.09.07 08:52:08 -04'00'
Additional Inspector(s) Carla Meyer (740860)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 28-31, September 1 and 5, 2023

The following intake(s) were inspected in this Critical Incident (CI) inspection:

- Intake: #00001768 - CI: M551-000010-22 - Injury to a resident of unknown cause.
- Intake: #00006124 - CI: M551-000003-22 - Alleged improper care.
- Intake: #00006509 - CI: M551-000013-22 - Improper/Incompetent treatment of resident.
- Intake: #00090820 - CI: M551-000013-23 - Injury to a resident of unknown cause.
- Intake: #00095162 - CI: M551-000015-23 - Fall resulting in fracture.

The following intakes were completed in this inspection: Intake: #00005328, CI: M551-000006-22; Intake: #00018824, CI: M551-000002-23 were related to falls.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

Rationale and Summary
On a specified date in 2022, a resident fell out of a mechanical lift during a transfer. The resident sustained an injury requiring transfer to hospital for treatment. Upon the home's investigation into the incident, they determined that a clip was not secured due to operator error which led to the resident sliding out of the lift to the ground.

An Associate Director of Resident Care (ADRC) acknowledged that staff did not use safe transferring techniques when transferring the resident.

Failure to ensure that staff used safe transferring techniques when assisting a resident led to actual harm.

Sources: Resident's clinical record, CI: M551-000013-22, the home's investigation notes, interviews with ADRC and other staff. [740738]

COMPLIANCE ORDER CO #001 Duty to protect

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 19 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

- Educate all registered staff on signs and symptoms of infections, including elevated blood sugar, and their role in monitoring and assessing residents who exhibit any signs or symptoms of infection and;

- Document and retain record of the education provided, including the date and the staff member who provided the education.

Grounds
On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and Ontario Regulation (O. Reg.) 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 19 of LTCHA.

The licensee has failed to ensure that a resident was protected from neglect.

Section 5 of O. Reg. 79/10 defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary
On a date in 2022, a resident was unwell. A Personal Support Worker (PSW) reported to the charge Registered Nurse (RN) that the resident had a change in condition and required attention. The PSW confirmed that the RN did not respond to the PSW's report. The Registered Practical Nurse (RPN) on the unit contacted another RN to attend to the resident. The RN reported that they then informed the charge RN that the resident was declining. The RN stated that the charge RN did not respond to the resident's change in condition and did not assess the resident. There was no documentation of an assessment by the charge RN.

The home's investigation notes determined that the RPN failed to communicate the change in condition to the charge RN and additionally, the RN failed to respond to the resident's change in condition as reported by the PSW.

The Director of Resident Care (DRC) acknowledged that the charge RN neglected to assess and respond to the resident's change in condition.

Failure to ensure that a resident was provided with the care required for their health, safety, and well-being demonstrated neglect.

Sources: Resident's clinical records, Critical Incident (CI): M551-000003-22, the home's investigation notes, interviews with PSW, RN, and DRC. [740738]

This order must be complied with by October 19, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.