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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Public Report

Report Issue Date: March 12, 2025

Inspection Number: 2025-1567-0001

Inspection Type:
Proactive Compliance Inspection

Licensee: The Regional Municipality of Niagara

Long Term Care Home and City: Linhaven, St Catharines

INSPECTION SUMMARY

This report has been modified to reflect administrative changes.

The inspection occurred onsite on the following date(s): February 27, 28, 2025 and March 3 to 7, 10 to 12, 2025

The following intake(s) were inspected:

- Intake: #00140442 - Proactive Compliance Inspection (PCI) for Linhaven.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards

Residents' Rights and Choices
Pain Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 20 (b)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(b) is on at all times;

On February 27, 2025, during a tour of the home, the communications and response system inside a resident's room in the Lincoln resident Home Area was not functioning when activated.

On the same day, staff provided the resident a resident-staff communication system which was functioning at all times.

Sources: Observations; Interviews with staff.

Date Remedy Implemented: February 27, 2025

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

The licensee has failed to ensure that procedures are implemented for cleaning and disinfecting resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A staff stated they used the squirt bottle to clean the shower chair. On March 5, 2025, observations of the squirt bottles in Merritt, Dalhousie, and Brock Resident Home Area shower rooms did not have labels. Observations of the squirt bottles in the Secord , Lincoln, Regatta, and Henley Home area shower room had unclear labels.

On March 6, 2025, staff confirmed that all affected shower room squirt bottles were clearly labelled.

Sources: Observations of all resident home area shower room squirt bottles; Interviews with staff; home's policy "Cleaning and Disinfection of Reusable Equipment (Reprocessing)", last revised October 2, 2024.

Date Remedy Implemented: March 6, 2025

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident was reassessed and their plan of care reviewed and revised when the use of an assistive device for meals was no longer necessary. The resident was observed during meal service on a specified date and they were not provided with the assistive device as per their plan of care. Staff interviews confirmed the resident no longer used the assistive device and the Registered Dietitian was not notified to complete an assessment.

Sources: Resident observation; review of resident's clinical record and interview with staff.

WRITTEN NOTIFICATION: Powers of Family Council

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 66 (3)
Powers of Family Council
s. 66 (3) 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.

The licensee has failed to ensure that they responded in writing within 10 days of receiving advice from the Family Council related to concerns or recommendations about the operation of the home. On a date October in 2024, Family Council sent a list of recommendations about the operation of the home to the licensee. The home acknowledged the e-mail and held a meeting to discuss the concerns, but a response was not provided in writing until January 2025.

Sources: E-mail record; interview with the Administrator and others.

WRITTEN NOTIFICATION: Doors in a home

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that all doors leading to non-residential areas are closed and locked when they are not being supervised by staff.

On a specified date, during observations of the home, the door to the tub room in the Merritt Home Area was open. A shower curtain was in between the door and the door frame preventing the door from fully closing.

Sources: Observations; Interviews with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee has failed to ensure that a resident received immediate treatment and interventions to promote healing and prevent infection for a wound in an identified area. Point of Care documentation indicated the resident had a change in skin integrity in the identified area. Treatment was not initiated immediately when the wound was identified.

Sources: Resident's clinical record; interview with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that a resident's wound in an identified area was reassessed at least weekly between a specified time frame.

Sources: Resident's clinical record; interview with staff.

WRITTEN NOTIFICATION: Drug destruction and disposal

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (3) (b)
Drug destruction and disposal
s. 148 (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care.
O. Reg. 246/22, s. 148 (3); O. Reg. 66/23, s. 31.

The licensee has failed to ensure that non-controlled substances were destroyed by a team acting together that composed of: one member of the registered nursing staff and one other staff member that were both appointed by the Director of Nursing and Personal Care.

Ontario Regulation 246/22 s. 148 (6) stated, "for the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable."

A staff confirmed that non-controlled substances were not destroyed by appointed home staff and that the medications were not altered or denatured by home staff prior to the destruction off site.

Sources: Home's policy "Medication Destruction and Disposal - (non narcotic/controlled medications)", last revised July 31, 2024; Interviews with staff.

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. iii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that a written record of the date when the results of the resident and family/caregiver experience survey were communicated to Family Council were included in the home's 2024-2025 Continuous Quality Improvement (CQI) initiative report.

Sources: Linhaven 2024-2025 Continuous Quality Improvement Initiative Report; interview with the CQI Advisor.

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. i.
Continuous quality improvement initiative report

s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
i. the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,

The licensee has failed to ensure that the outcomes of the actions taken to improve the long-term care home, and the care, services, program and goods based on the documentation of the results of the resident and family/caregiver experience survey were included in the home's 2024-2025 CQI initiative report.

Sources: Linhaven 2024-2025 Continuous Quality Improvement Initiative Report; interview with the Manager of Planning, Evaluation and CQI and Administrator.

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. ii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
ii. any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions,

The licensee has failed to ensure that the home's 2024-2025 CQI initiative report included dates actions were implemented for the home's other priority areas of quality improvement which included equity and indigenous, patient safety and health equity.

Sources: Linhaven 2024-2025 Continuous Quality Improvement Initiative Report; interview with the Manager of Planning, Evaluation and CQI and Administrator.

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