



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

Hamilton Service Area Office  
119 King Street West, 11th Floor  
HAMILTON, ON, L8P-4Y7  
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Division de la responsabilisation et de la performance du système de santé  
Direction de l'amélioration de la performance et de la conformité

**Public Copy/Copie du public**

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 18, 2013	2013_214146_0043	H-000089- 13, H- 000403-13	Follow up

**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)

**Inspection Summary/Résumé de l'inspection**



The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): August 29, September 5, 10, 11, 12, 2013

This follow-up inspection was conducted concurrently with 2 Critical Incident inspections H-000189-13, H-000547-13 and 3 complaint inspections H-000442-13, H000216-13 and H-000323-13.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), registered staff, Personal Support Workers (PSW's), physiotherapy staff, hairdressers, dietary staff, residents and family members.

During the course of the inspection, the inspector(s) reviewed the home's audits of transfer assessments and plans of care, residents' health records, policy and procedures related to prevention of abuse and sign-up sheets for prevention of abuse training.

The following Inspection Protocols were used during this inspection:  
Personal Support Services  
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités



<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>
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**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

**Specifically failed to comply with the following:**

**s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:**

- 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**



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The licensee, who had reasonable grounds to suspect that the following occurred, did not report the incident and the information upon which it was based to the Director: Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm; and, abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

(a) Resident #002 sustained injury in August 2013 during a transfer procedure. The home's internal investigation identified that the workers failed to give proper care. The home did not report the improper care to the Director until advised to do so several weeks later during a complaint inspection.

(b) In August 2013, staff witnessed another staff verbally and/or emotionally abusing a resident. The report was not immediately sent to the Director. The report was sent 6 days later. This information was confirmed by the DOC and ADOC. [s. 24. (1)]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff**

**Specifically failed to comply with the following:**

**s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:**

**1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).**

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**Findings/Faits saillants :**



The licensee did not ensure that all staff who provide direct care to residents receive the training provided for in subsection 76(7) of the Act based on the following: 1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76(7) of the Act.

Abuse recognition and prevention training has not been provided to all employees who provide direct care to residents annually:

2 out of 2 hairdressing staff interviewed stated they have not ever had abuse recognition and prevention training;

3 nursing staff and 1 dietary staff on duty on a date in August 2013 stated they had not had the training within the past year or two.

This information was confirmed by the administrator who stated that between 60 and 70 employees had not had the training in the past year. [s. 221. (2) 1.]

**THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/  
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:**

<b>COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:</b>			
<b>REQUIREMENT/ EXIGENCE</b>	<b>TYPE OF ACTION/ GENRE DE MESURE</b>	<b>INSPECTION # / NO DE L'INSPECTION</b>	<b>INSPECTOR ID #/ NO DE L'INSPECTEUR</b>
LTCHA, 2007 S.O. 2007, c.8 s. 6. (4)	CO #001	2013_201167_0017	146



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Issued on this 3rd day of October, 2013

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

*BARBARA NAYKALYK-HULL*



Ministry of Health and  
Long-Term Care

Ministère de la Santé et  
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Order(s) of the Inspector  
Pursuant to section 153 and/or  
section 154 of the *Long-Term Care  
Homes Act, 2007, S.O. 2007, c.8*

Ordre(s) de l'inspecteur  
Aux termes de l'article 153 et/ou  
de l'article 154 de la *Loi de 2007 sur les foyers  
de soins de longue durée, L.O. 2007, chap. 8*

Health System Accountability and Performance Division  
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé  
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : BARBARA NAYKALYK-HUNT (146)

Inspection No. /

No de l'inspection : 2013\_214146\_0043

Log No. /

Registre no: H-000089-13, H-000403-13

Type of Inspection /

Genre d'inspection: Follow up

Report Date(s) /

Date(s) du Rapport : Sep 18, 2013

Licensee /

Titulaire de permis : THE REGIONAL MUNICIPALITY OF NIAGARA  
2201 ST. DAVID'S ROAD, THOROLD, ON, L2V-4T7

LTC Home /

Foyer de SLD : LINHAVEN  
403 Ontario Street, St. Catharines, ON, L2N-1L5

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : May Simpson

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To THE REGIONAL MUNICIPALITY OF NIAGARA, you are hereby required to  
comply with the following order(s) by the date(s) set out below:



Ministry of Health and  
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Ministère de la Santé et  
des Soins de longue durée

Order(s) of the Inspector  
Pursuant to section 153 and/or  
section 154 of the *Long-Term Care  
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Ordre(s) de l'inspecteur  
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**Order # /**                      **Order Type /**  
**Ordre no : 001**              **Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Linked to Existing Order /**  
**Lien vers ordre existant:** 2013\_105130\_0004, CO #001;

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan demonstrating how the home will ensure that any person who has reasonable grounds to suspect that :

1. improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident; or,
2. abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident immediately reports the suspicion and the information upon which it is based to the Director. The plan shall be submitted electronically to Barb Naykalyk-Hunt, LTC Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, Hamilton Service Area Office at Barbara.Naykalyk-Hunt@ontario.ca by the end of business on October 11, 2013.

**Grounds / Motifs :**





**Ministry of Health and  
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**Ministère de la Santé et  
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**Ordre(s) de l'inspecteur**  
Aux termes de l'article 153 et/ou  
de l'article 154 de la *Loi de 2007 sur les foyers  
de soins de longue durée*, L.O. 2007, chap. 8

1. The following non-compliance was previously issued September 21, 2010 as a WN, October 26, 2010 as a VPC, May 12, 2011 as a VPC and February 1, 2013 as a CO.

The licensee, who had reasonable grounds to suspect that the following occurred, did not report the incident and the information upon which it was based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm. 2. abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident

Resident #002 sustained injury in August 2013 during a transfer procedure. The home's internal investigation ruled that the workers failed to give proper care. The home did not report the improper care to the Director until advised to do so several weeks later during a complaint inspection.

In August 2013 staff witnessed another staff verbally and/or emotionally abusing a resident #900. The report was not immediately sent to the Director. The report was sent 6 days later. This information was confirmed by the DOC and ADOC. (146)

**This order must be complied with by /**

**Vous devez vous conformer à cet ordre d'ici le : Oct 11, 2013**



**Ministry of Health and  
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### **REVIEW/APPEAL INFORMATION**

#### **TAKE NOTICE:**

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director  
c/o Appeals Coordinator  
Performance Improvement and Compliance Branch  
Ministry of Health and Long-Term Care  
1075 Bay Street, 11th Floor  
TORONTO, ON  
M5S-2B1  
Fax: 416-327-7603



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When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar  
151 Bloor Street West  
9th Floor  
Toronto, ON M5S 2T5

Director  
c/o Appeals Coordinator  
Performance Improvement and Compliance  
Branch  
Ministry of Health and Long-Term Care  
1075 Bay Street, 11th Floor  
TORONTO, ON  
M5S-2B1  
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website [www.hsarb.on.ca](http://www.hsarb.on.ca).



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## **RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL**

### **PRENDRE AVIS**

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le titulaire de permis souhaite que le directeur examine;
- c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur  
a/s Coordinateur des appels  
Direction de l'amélioration de la performance et de la conformité  
Ministère de la Santé et des Soins de longue durée  
1075, rue Bay, 11<sup>e</sup> étage  
Ontario, ON  
M5S-2B1  
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.



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Aux termes de l'article 153 et/ou  
de l'article 154 de la *Loi de 2007 sur les foyers  
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En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire  
Commission d'appel et de révision  
des services de santé  
151, rue Bloor Ouest, 9e étage  
Toronto (Ontario) M5S 2T5

Directeur  
a/s Coordinateur des appels  
Direction de l'amélioration de la performance et de la  
conformité  
Ministère de la Santé et des Soins de longue durée  
1075, rue Bay, 11e étage  
Ontario, ON  
M5S-2B1  
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au [www.hsarb.on.ca](http://www.hsarb.on.ca).

Issued on this 18th day of September, 2013

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur :

BARBARA NAYKALYK-HUNT

Service Area Office /

Bureau régional de services : Hamilton Service Area Office