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
Feb 13, 2018	2017_560632_0023	025924-17	Resident Quality Inspection

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

YULIYA FEDOTOVA (632), AILEEN GRABA (682), GILLIAN HUNTER (130), KELLY CHUCKRY (611)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): November 20, 21, 22, 23, 24, 27, 28, 29, 30, December 1, 4, 5, 2017.

The following inspections were completed concurrently with the Resident Quality Inspection:

Critical Incident System Report:
025999-16-related to: Responsive Behaviors

014166-17-related to: Prevention of Abuse and Neglect
029222-16-related to: Prevention of Abuse and Neglect
029738-16-related to: Falls Prevention
033828-16-related to: Medications
023947-16-related to: Prevention of Abuse and Neglect
022792-17-related to: Prevention of Abuse and Neglect
014149-17-related to: Prevention of Abuse and Neglect
035009-16-related to: Prevention of Abuse and Neglect
005752-16-related to: Falls Prevention
007322-17-related to: Falls Prevention
000081-17-related to: Prevention of Abuse and Neglect

Inquiries:
012835-18-related to Staffing
018865-17-related to Staffing
008822-17-related to Prevention of Abuse and Neglect

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Residents Care (DRC), Clinical Documentation Informatics (CDI) Lead #1, Clinical Documentation Informatics (CDI) Lead #2, Personal Support Workers (PSWs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), with residents and their families.

During the course of the inspection, the inspector(s) conducted a tour of the home, including resident rooms and common areas, reviewed infection prevention and control policy, reviewed inspection related documentation, relevant clinical records, relevant policies, procedures, and practices within the home, reviewed meeting minutes, investigation notes, staff files, observed the provision of care and medication administration.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **9 WN(s)**
- **1 VPC(s)**
- **1 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all residents were protected from abuse by anyone.

A) On an identified date in August, 2016, the licensee submitted a mandatory report to the Ministry of Health and Long Term Care (MOHLTC) (M551-000025-16) for resident to resident sexual abuse.

The mandatory report indicated that resident #027 was seen leaving an area where resident #028 was. Resident #028 was then observed by staff in a specific condition.

A review of the clinical record revealed that the Substitute Decision Maker (SDM) for resident #028 communicated concerns for the resident's safety, when informed of the incident that involved co-resident #027's identified behaviour.

Resident #027 had symptoms related to their memory. They also had documented behaviours related to verbal abuse to staff.

A review of the clinical record identified resident #028 had an identified diagnosis and was reliant on staff.

B) On an identified date in September, 2016, the licensee submitted a mandatory report to the MOHLTC (MM551-000030-16) for resident to resident sexual abuse. The mandatory report indicated that resident #027 was witnessed demonstrating a behavior towards resident #028.

Interview with registered staff #346 and #360 on an identified date in December, 2017, acknowledged that resident #028 had not consented to the identified contact from resident #027 on an identified date in August, 2016, or on an identified date in September, 2016, and that the licensee had failed to ensure that resident #028 was protected from sexual abuse, by anyone.

Please note: this non-compliance was issued as a result of Critical Incident (CI) log #023947-16 and log #029222-16, which were conducted concurrently with the RQI. [s. 19. (1)]

2. A) On an identified date in July, 2017, the licensee submitted a mandatory report to the MOHLTC (M551-000016-17) for resident to resident sexual abuse.
The mandatory report indicated resident #014 and resident #015 were found together by staff. Resident #014 was exhibiting an identified behavior towards resident #015.

A review of the clinical record identified resident #015 had an identified diagnosis.

A review of the clinical record identified resident #014 had an identified diagnosis.

Both residents were identified to have a common interest in April, 2017, at which time interventions were put in place, to prevent any risk of an identified behavior.

B) On an identified date in September, 2017, the licensee submitted a subsequent mandatory report to the MOHLTC (M551-000028-17) for resident to resident sexual abuse.

The mandatory report indicated that resident #014 and resident #015 were involved in an identified activity.
Resident #015 was observed exhibiting an identified behavior towards resident #014.
Interview with registered staff #356 on an identified date in November, 2017, acknowledged that both residents were not orientated to person.

Registered staff #356 confirmed that neither resident was able to, nor had consented to the identified activity due to identified impairments on the evening of an identified date in July, 2017, or on an identified date in September, 2017, and that the licensee had failed to ensure the resident was protected from sexual abuse, by anyone.

Please note: this non-compliance was issued as a result of CI log #022792-17 and log #014149-17, which were conducted concurrently with the RQI. [s. 19. (1)]

3. According to a mandatory report submitted to the MOHLTC (M551-000020-17), in July, 2017, staff #235 witnessed resident #024 demonstrating a behaviour towards resident #023, which was considered abuse.

Resident #024 was beside resident #023 and they exhibited an identified behavior towards resident #023.

Staff #383 confirmed on an identified date in November, 2017, that the incident of an identified behavior between the two residents was non-consensual for resident #023.

On an identified date in July, 2017, resident #023 was not protected from abuse.

Please note: this non compliance was issued as a result of CI log #014166-17, which was conducted concurrently with the RQI. [s. 19. (1)]

4. According to the clinical record on an identified date in September, 2017, staff #299 witnessed resident #025 exhibiting an identified behavior towards resident #026.

The DRC confirmed that the interaction between the residents was non-consensual. The plan of care for resident #025, with a revision date in September, 2017, included that interventions were in place to manage the resident's sexual responsive behaviours.

On an identified date in September, 2017, resident #026 was not protected from abuse. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible.

1. A review of records identified that on an identified date in August, 2016, resident #019 exhibited identified behaviours towards resident #021.

A progress note entry for resident #019, after the incident, identified that an intervention was put in place.
A second incident of identified behaviours, occurred a short time after the first incident, by resident #019 towards resident #020.
The progress note after this second incident indicated that the intervention was not in place.

A review of the written plan of care for resident #019 at the time of the above noted incidences outlined interventions for an identified behavior towards staff and residents.
In an interview with the CDI Lead #1, it was acknowledged that when a resident on an identified unit, it was required the specific intervention, this was to be assigned by the registered staff on the unit and that when the specific intervention was in place, it was to be constant.

Interviews conducted with staff #168, #237, and #288, who were all present on the unit on an identified date in August, 2016, when the incidences of identified behaviours occurred, acknowledged that the intervention was not provided to resident #019 immediately after the first or second incident and that the strategy was not implemented in response to identified behaviors on the identified day.

Please note: this non-compliance was issued as a result of a CI log #025999-16, which was conducted concurrently with the RQI. [s. 53. (4) (b)]

2. Resident #027 exhibited identified behaviours.

Resident #027 displayed identified responsive behaviours and had a specific intervention in place to assist in the management of the behaviours.
Their plan of care included an intervention of an identified device (revision on an identified date in August, 2016).
A mandatory report, M551-000030-16, submitted by the home on an identified date in September, 2016, revealed that resident #027 was involved in a resident to resident abuse incident occurring on an identified date in September, 2016.
Resident #027 was found in a co-residents room demonstrating an identified activity towards resident #028.
A clinical record review revealed, a progress note written on an identified date in September, 2016, stated that an identified device did not fucntion in resident's #027 room that evening.
Interview with staff #216 confirmed, on an identified date in December, 2017, that it was

the expectation that the identified intervention was checked on each shift to ensure they were enabled and in working order.
Registered staff #360 acknowledged the strategy of an identified device had not been implemented on an identified date in September, 2016, to respond to resident demonstrating identified behaviours. [s. 53. (4) (b)]

3. Resident #015 exhibited identified behaviours. It was also documented that the health care team had decided to address behaviours within the care plan to minimize risks. Resident's #015's plan of care included an intervention during the afternoon shift, which was revised on an identified date in July, 2017.

A clinical record review revealed resident #015 was involved in resident to resident sexual abuse, in the evening of an identified date in August, 2017, when resident #014 was found demonstrating a specific activity towards resident #015.

On an identified date in September, 2017, a mandatory report #M551-000028-17, was submitted for resident to resident sexual abuse.
Resident #015 was witnessed by staff demonstrating an identified activity towards resident #014 in an identified home area

It was confirmed during an interview with staff #434, on an identified date in November, 2017, that the strategy had not been implemented on an identified date in August or on an identified date in September, 2017, in response to resident's #015 identified behaviours.

Please note: this non-compliance was issued as a result of CI log #022792-17 and log #014149-17, which were conducted concurrently with the RQI. [s. 53. (4) (b)]

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 and ensuring that for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.

WN #3: 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. (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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or when care set out in the plan was no longer necessary.

The plan of care for resident #003, specifically the care plan reviewed an identified date in September, 2017, revealed that the resident had alterations in bladder and bowel functions and required interventions to remain clean and dry. The Minimum Data Set (MDS) Quarterly Review Assessment completed on an identified date in September, 2017, indicated under Section H - continence in last 14 days, that the resident had no alterations in bladder and bowel functions.
On an identified date in November, 2017, MDS Residents Assessment Instrument (RAI) Co-ordinator #100, confirmed that the assessment completed on an identified date in September, 2017, was accurate and that the plan of care was not updated when the resident had alterations in bladder and bowel functions. [s. 6. (10) (b)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that there was at least one registered nurse, who was an employee of the licensee and was a member of the regular nursing staff on duty and present at all times.

Ontario Regulation 79/10 section 45, allowed for exceptions for the requirement of one RN on duty and present at all times, under specific situations, for homes with less 129 beds and for small homes at hospitals. Linhaven did not qualify for any exceptions as specified in the regulations.

Linhaven was a long-term care home with a licensed capacity of 248 beds.
The Administrator verified the staffing pattern for the home included at least one RN (not including the DRC) on duty and present at all times, in addition to a mix of RPNs and PSWs to meet the nursing and personal care needs of residents.

Interview with the Administrator identified that currently the home has one full-time equivalent (FTE) RN vacancy that has been filled temporarily, therefore all RN positions are currently filled according to the staffing plan; however, from March – June, 2017, there was an unfilled RN vacancy that the home could not fill.

It was identified that the home consistently offered additional shifts and overtime to their RNs to fill these vacant shifts; however, when the RNs employed by the home were unwilling or unable to work the vacant shifts the home filled the shifts with RPNs employed by the home and with RNs employed by an employment agency, in an effort to provide RN coverage 24 hours a day seven days a week.

The Registered Nurses Staffing Schedules were provided for some identified dates in March, April and May, 2017, on request.

A review of the schedules, with the Administrator confirmed that over the identified time

period there were 11 occasions when the only RN in the home was an agency RN.

It was verified by the Administrator that the agency RNs were not members of the regular nursing staff and that no circumstances were present, to their knowledge, which permitted an exception to the requirements of section 8(3), by virtue of section 45 of the Regulation.

The home did not ensure that there was at least one registered nurse who was an employee of the licensee and was a member of the regular nursing staff on duty and present at all times.

Please note: this non-compliance was issued as a result of Complaint inspection log #018865-17, which was conducted concurrently with the RQI. [s. 8. (3)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with applicable requirements under the Act.

Ontario Regulation 79/10 section 48 requires the home to have a falls prevention and management program to reduce the incidents of falls and the risk of injury.

Home's policy titled Post Fall Assessment INDEX NO: PCS04-011 (revised January 20, 2016), contained the information that Glasgow Coma Scale assessment was to be initiated, when resident sustained an identified injury.
The Head Injury Routine (HIR) policy INDEX NO: PCS04-003 (revised August 10, 2015), indicated that HIR (the Glasgow Coma Scale) was to be completed for 48 hours after the fall of the resident and the following timelines were to be used by the registered staff: "neuro vitals and assessment every 30 min for one hour; should resident present as stable, progress to vitals and assessment every hour for four hours; should resident present as stable, progress to vitals and assessment every 8 hours for 48 hour period from time of injury. If resident remains stable after 48 hours described above discontinue assessment".

A review of a CIS submitted by the home and progress notes indicated that on an identified date in April, 2017, resident #011 had a fall and sustained an identified injury. According to the progress notes from identified dates in April, 2017, HIR was completed for approximately 14 hours, post 24 hour HIR assessment. The next HIR assessment was completed 9 hours later.
Staff #352 was interviewed on an identified date in November, 2017, and indicated that HIR was to be completed for unwitnessed falls and when the resident sustained an identified injury, as per HIR schedule, based on the Post Fall Assessment Policy, which also referred to the Head Injury Routine Policy, which was to be every 30 min for one hour; then every hour for four hours, and then every 8 hours for 48 hour period from time of injury.
On an identified date in November, 2017, CDI Lead #1, confirmed that Glasgow Coma Scale was not completed based on the home's Head Injury Routine for resident #011, who sustained an identified injury on an identified date in April, 2017. The CDI Lead #1 also indicated that there were no additional records of HIR completed for resident #011, which was acknowledged by the Administrator on an identified date in November, 2017.

The home did not ensure that the Head Injury Routine Policy was complied with by the registered staff for fall of resident #011, who sustained an identified injury.

Please note: this non-compliance was issued as a result of CI log #007322-17, which was conducted concurrently with the RQI. [s. 8. (1) (a),s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

1. A review of the home's policy, "Abuse and Neglect - Zero tolerance (Index No: RR00-001)", reviewed, December 15, 2016, revealed that under Procedure - Reporting and Investigation of Abuse and Neglect: 14 "The Administrator/DRC/Charge Nurse will notify the Ministry of Health and Long Term Care (MOHLTC) via phone immediately. The Administrator/DRC or delegate will complete the Critical Incident report on the Ministry website as indicated in the policy (ADO5-002) Reports, Complaints-Mandatory and Critical Incidents Report Requirements."

A clinical record review revealed that on an identified date in August, 2017, resident #014 was found in an identified home area and was exhibiting an identified activity towards another resident.
Interview with registered staff #393 on an identified date in November, 2017, confirmed that on an identified date in August, 2017, resident #014 exhibited an identified behavior towards resident #015. Further record review revealed a team conference held on an identified date in July, 2017, which identified both resident #014 and resident #015 were unable to provide consent for an identified behavior.
Resident #015 had an identified diagnosis.
A review of the clinical record identified that resident #014 had an identified diagnosis.

An interview with the DRC on an identified date in November, 2017, they acknowledged that this witnessed incident should have been reported immediately and the home failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Please note: this non-compliance was issued as a result of CI log #022792-17 and log #014149-17, which were conducted concurrently with the RQI. [s. 20. (1)]

2. The home's policy titled: "Abuse and Neglect - Zero Tolerance (Index No: RR00-001)", revised July 30, 2014, stated the following: "1. All incidents of abuse and neglect will be fully investigated, and 14. The Administrator/DRC/Charge Nurse will notify the Ministry of Health and Long-Term Care via phone immediately. The Administrator/DRC or delegate will complete the Critical Incident report on the Ministry web-site as indicated in the policy (AD05-002) Reports, complaints "Mandatory and Critical Incidents Reports Requirements".

On an identified date in September, 2017, staff #299 witnessed resident #025 exhibited an identified activity towards resident #026.
The DRC confirmed that the interaction between the residents was non-consensual.

The DRC confirmed, in an interview on an identified date in November, 2017, that the incident was not reported to the ministry immediately via telephone nor was a critical incident submitted to the Director.
On an identified date in September, 2017, the home's policy titled: "Abuse and Neglect - Zero Tolerance (Index No: RR00-001)", revised July 30, 2014, was not complied with. [s. 20. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A review of the clinical record revealed that on an identified date in August, 2017, resident #015 and #014 exhibited identified behaviours towards each other, which resulted in an incident of resident to resident sexual abuse.
During an interview, on an identified date in November, 2017, DRC #420 confirmed that the incident was documented in resident #014's clinical record, but was not documented in the clinical record of resident #015.
It was acknowledged by the DRC, that not all actions taken with respect to the incident involving resident #015 on an identified date in August, 2017, under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Please note: this non-compliance was issued as a result of CI log #022792-17 and log #014149-17, which were conducted concurrently with the RQI. [s. 30. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).
2. The physical device is well maintained. O. Reg. 79/10, s. 110 (1).
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions.

The manufacturer's instructions directed staff to apply the device in a specific fashion.

On an identified date in November, 2017, resident #016 was observed in their mobility device with a safety device applied. The resident was not able to remove the device on command. The device was observed to not be applied in accordance with manufacturer's instructions.

Registered staff #351 observed the device and confirmed that it was not applied as per manufacturer's instructions.

On an identified date in November, 2017, restraining of a resident by a physical device under section 31 or section 36 of the Act: was not complied with when staff failed to apply the physical device in accordance with the manufacturer's instructions. [s. 110. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

The medication incident reports reviewed from identified dates in July, 2017 until September, 2017, revealed that nine of thirteen incident reports were not consistently reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

The DRC was interviewed on an identified date in November, 2017, and confirmed that not all incidents were reported to all identified parties. [s. 135. (1)]

Issued on this 20th day of February, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	YULIYA FEDOTOVA (632), AILEEN GRABA (682), GILLIAN HUNTER (130), KELLY CHUCKRY (611)
Inspection No. / No de l'inspection :	2017_560632_0023
Log No. / No de registre :	025924-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 13, 2018
Licensee / Titulaire de permis :	THE REGIONAL MUNICIPALITY OF NIAGARA 2201 ST. DAVID'S ROAD, P.O. Box344, THOROLD, ON, L2V-3Z3
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 :	Karen Pow

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

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The Licensee shall:

1. Ensure that all residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

2. Ensure that interventions are in place for residents #014, #024, #025 and #027 to manage the residents' sexual responsive behaviours.

3. Ensure staff follow residents #014, #024, #025 and #027 plans of care, when managing the residents' sexual responsive behaviours.

Grounds / Motifs :

1. This order is made up on the application of the factors of severity (2), scope (2), and compliance history (2), in keeping with O. Reg. 79/10, s. 299. This is in respect to the severity of minimal harm/risk, the scope of this being pattern incidents, and the licensee history of previous non-compliance (unrelated), during the Resident Quality Inspection in September 28, 2016.

1. The licensee failed to ensure that all residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

According to the clinical record on an identified date in September, 2017, staff #299 witnessed resident #025 exhibiting an identified behavior towards resident #026.

The DRC confirmed that the interaction between the residents was non-consensual.

The plan of care for resident #025, with a revision date in September, 2017, included that interventions were in place to manage the resident's sexual responsive behaviours.

On an identified date in September, 2017, resident #026 was not protected from abuse. (130)

2. The licensee failed to ensure that all residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

According to a mandatory report submitted to the MOHLTC (M551-000020-17), in July, 2017, staff #235 witnessed resident #024 demonstrating a behaviour towards resident #023, which was considered abuse.

Resident #024 was beside resident #023 and they exhibited an identified behavior towards resident #023.

Staff #383 confirmed on an identified date in November, 2017, that the incident of an identified behavior between the two residents was non-consensual for resident #023.

On an identified date in July, 2017, resident #023 was not protected from abuse.

Please note: this non compliance was issued as a result of CI log #014166-17, which was conducted concurrently with the RQI.
(130)

3. The licensee failed to ensure that all residents were protected from abuse by anyone.

A) On an identified date in July, 2017, the licensee submitted a mandatory report to the MOHLTC (M551-000016-17) for resident to resident sexual abuse.
The mandatory report indicated resident #014 and resident #015 were found together by staff. Resident #014 was exhibiting an identified behavior towards resident #015.

A review of the clinical record identified resident #015 had an identified diagnosis.

A review of the clinical record identified resident #014 had an identified diagnosis.

Both residents were identified to have a common interest in April, 2017, at which time interventions were put in place, to prevent any risk of an identified behavior.

B) On an identified date in September, 2017, the licensee submitted a subsequent mandatory report to the MOHLTC (M551-000028-17) for resident to resident sexual abuse.

The mandatory report indicated that resident #014 and resident #015 were involved in an identified activity.
Resident #015 was observed exhibiting an identified behavior towards resident #014.
Interview with registered staff #356 on an identified date in November, 2017, acknowledged that both residents were not orientated to person.

Registered staff #356 confirmed that neither resident was able to, nor had consented to the identified activity due to identified impairments on the evening of an identified date in July, 2017, or on an identified date in September, 2017, and that the licensee had failed to ensure the resident was protected from sexual abuse, by anyone.

Please note: this non-compliance was issued as a result of CI log #022792-17 and log #014149-17, which were conducted concurrently with the RQI. (682)

4. The licensee failed to ensure that all residents were protected from abuse by anyone.

A) On an identified date in August, 2016, the licensee submitted a mandatory report to the Ministry of Health and Long Term Care (MOHLTC) (M551-000025-16) for resident to resident sexual abuse.

The mandatory report indicated that resident #027 was seen leaving an area where resident #028 was. Resident #028 was then observed by staff in a specific condition.

A review of the clinical record revealed that the Substitute Decision Maker (SDM) for resident #028 communicated concerns for the resident's safety, when

informed of the incident that involved co-resident #027's identified behaviour.

Resident #027 had symptoms related to their memory. They also had documented behaviours related to verbal abuse to staff.
A review of the clinical record identified resident #028 had an identified diagnosis and was reliant on staff.

B) On an identified date in September, 2016, the licensee submitted a mandatory report to the MOHLTC (MM551-000030-16) for resident to resident sexual abuse. The mandatory report indicated that resident #027 was witnessed demonstrating a behavior towards resident #028.

Interview with registered staff #346 and #360 on an identified date in December, 2017, acknowledged that resident #028 had not consented to the identified contact from resident #027 on an identified date in August, 2016, or on an identified date in September, 2016, and that the licensee had failed to ensure that resident #028 was protected from sexual abuse, by anyone.

Please note: this non-compliance was issued as a result of Critical Incident (CI) log #023947-16 and log #029222-16, which were conducted concurrently with the RQI. (682)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 23, 2018

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, commercial courier or by fax upon:

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

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Long-Term Care Inspections 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.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 13th day of February, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector /
Nom de l'inspecteur : Yuliya Fedotova

Service Area Office /
Bureau régional de services : Hamilton Service Area Office