Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d’inspection prévue 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 Rapport	Inspection No / No de l’inspection	Log # / No de registre	Type of Inspection / Genre d’inspection
Aug 8, 2019	2019_546750_0007	030202-18, 002979-19, 004537-19, 013388-19	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): July 22, 23, 24, 25, 26, 29, 30, 31, and August 1, 2, 2019.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Associate Directors of Resident Care (ARDC), 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 this inspection, the inspector(s) observed the provision of resident care and reviewed clinical health records, investigation notes, staffing schedules, meeting minutes, and policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

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)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2018_661683_0020	750

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan of care.

A review of a complaint regarding resident #002, identified concerns with continence care.

Resident #002 was observed on a specified date during an identified time. During the identified time the resident was transported from one area of the home to another. Staff assisted the resident and afterwards, transported them back. During the identified time, resident #002 was not observed to have been toileted.

A review of resident #002's written plan of care identified that resident #002 was on a toileting program and scheduled to be toileted at an identified time.

In an interview with Personal Service Worker (PSW) #127 on a specified date and time, they acknowledged that resident #002 required a certain level of assistance with activities of daily living (ADLs). PSW acknowledged that at the time of the interview resident #002 had not been toileted as per their toileting routine.

The licensee failed to ensure that resident #002 was toileted as specified in the plan of care. [s. 6. (7)]

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 be implemented voluntarily.

WN #2: 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 relating to continence care.

A review of a complaint regarding resident #002 identified concerns with continence care.

The written plan of care for resident #002 identified that the resident was on a toileting program. Review of Point Click Care (POC) for a specified time, did not include documentation that resident was toileted as per their plan of care on an identified number of occasions. In addition, the written plan of care for resident #010 identified that they were on a toileting program. Review of POC for a specified time, did not include documentation that the resident was toileted as specified in their care plan, on an identified number of occasions.

In interviews with PSW #120 and PSW #126, they noted that both resident #002 and #010 were on toileting programs. PSW #120 stated that documentation was to be completed in POC, and both PSWs acknowledged the challenges with time and technology creating barriers to complete documentation before the end of a shift. PSW#120 acknowledged that resident #002 was toileted as per the identified schedule on an identified date and PSW #126 acknowledged resident #010 was toileted as scheduled on a specified date. Both PSW #120 and #126 noted that they did not document the task for the specified dates.

During an interview with Administrator #122, they acknowledged that the home's expectation is that staff were to complete and document any identified tasks as found in a resident's point of care.

The home failed to ensure that interventions were documented relating to continence care for resident #002 and resident #010. [s. 30. (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 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. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of an incident that caused an injury to resident #001 for which the resident was taken to a hospital and resulted in a significant change in the resident’s health condition, no later than three business days after the occurrence of the incident.

A complain was submitted to the Director on an identified date, related to concerns pertaining to an unwitnessed fall sustained by resident #001.

A clinical review indicated that resident #001 was assessed as a high risk for falls. Further review indicated that the resident had sustained falls on identified dates. A review of the critical incident system (CIS) submitted to the Director on a specified date, indicated resident #001 experienced a fractured as result of a fall sustained on an identified date. Resident #001 was transferred to hospital for medical intervention post fall on a specified date. A Resident Assessment Instrument, Minimum Data Set (RAI-MDS) from an identified date, indicated resident #001 had a significant change in health condition. Progress notes did not include any documentation of staff contacting the hospital to determine if resident #001 injury resulted in significant change in health condition.

During an interview, Manager of Long Term Care Behavioural Support (MLTCBS)#105 confirmed that registered staff had not contacted the hospital to determine whether the injury sustained on an identified date, had resulted in significant change in resident's #001 health condition. MLTCBS#105 also stated that they did not submit the CIS to the Director within three business days of the incident. [s. 107. (3.1)]

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.