Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Dec 10, 2020	2020_704682_0015	002686-20, 010149-20, 016855-20, 017246-20, 017631-20, 020468-20, 023590-20	Critical Incident System

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 Catherines ON L2N 1L5

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

AILEEN GRABA (682), CATHY FEDIASH (214)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 5, 6, 9, 10, 12, 13, 16, 17, 18, 19, 20, 23, 24, 25, 26, 27, 30, and December 1, 2, 2020.

The following Critical Incident System inspections were conducted:
002686-20 related to prevention of abuse
010149-20 related to fall prevention
016855-20 related to fall prevention
017246-20 related to fall prevention
017631-20 related to fall prevention
020468-20 related to fall prevention
023590-20 related to fall prevention, lifts and transfers

The following Complaint inspections were conducted concurrently with this Critical Incident System inspections:
011518-20 related to personal support services, continence, lifts and transfers
019047-20 related to falls prevention and hospitalization/change in condition
021891-20 related to infection prevention and control
022159-20 related to personal support services, housekeeping, medication administration, infection prevention and control

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Associate Director of Care (ARDC), Manager of LTC Behaviour Support, Dietary Manager/Acting Environmental Manager, Resident and Community Programs Manager, the Associate Director of Clinical and Support Programs, Dietary Aids, Clinical Documentation and Informatics lead, Hairdresser, Housekeeping, Resident and Family Support worker, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

During the course of this inspection, the inspector(s) observed the provision of the care and reviewed clinical health records, complaint log binder, investigation notes, staffing schedules, meeting minutes, program evaluations and training records, policy and procedures.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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)**

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. 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 :

1. The licensee has failed to ensure that they complied with paragraph 2 of section 24. (1) of the LTCHA related to reporting certain matters to the Director.

Section 24. (1) paragraph 2 of the LTCHA states that "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:
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."

Furthermore, section 152. (2) of the LTCHA states that "where an inspector finds that a staff member has not complied with subsection 24. (1) or 26. (1), the licensee shall be deemed to have not complied with the relevant subsection and the inspector shall do at least one of the actions set out in subsection (1) as the inspector considers appropriate."

As per section 2. of the Ontario Regulation 79/10, physical abuse is defined as "the use of physical force by anyone other than a resident that causes physical injury or pain." Verbal abuse is defined as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident."

According to licensee's investigation notes, two Personal Support Workers (PSW) were assisting a resident when one of the PSW's handled the resident in a rough manner. The incident was not reported immediately. The Associate Director of Resident Care (ADRC) confirmed that the incident was not reported immediately. By the inaction of the PSW and not reporting the incident immediately when they witnessed it, the resident's safety and well-being were placed at risk.

Sources: The licensee's investigation notes, Interviews with PSW and ADRC. [s. 24. (1)]

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 ensure compliance with paragraph 2 of section 24. (1) of the LTCHA related to reporting certain matters to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that personal support workers (PSW) used safe transferring and positioning techniques when assisting a resident.

Investigation notes and progress notes identified that a resident was being assisted by PSWs while being transferred and fell. Both PSW's confirmed in an interview that the resident had fallen and that the equipment must have loosened sometime during the transfer. In an interview, the Director of Resident Care (DRC) and Associate Director of Resident Care (ADRC) stated that the PSW's checked and secured the equipment before the transfer but could not confirm that staff checked the equipment during the transfer process. Because staff did not use safe transferring techniques with each and every transfer, the resident was at risk for injury and falls.

Sources: The licensee's investigation notes, resident's progress notes, lift and transfer policy, interviews with PSW, ARDC, DRC. [s. 36.]

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 ensure that staff use safe transferring and positioning devices or techniques when assisting residents, 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 has failed to ensure that an incident involving a resident for which they were taken to hospital and the licensee determined or remained unsure whether the injury resulted in a significant change in their health condition, informed the Director of the incident no later than three business days after the occurrence.

Review of a Critical Incident System (CIS) report of a resident indicated the resident sustained a previous fall. Review of the resident's clinical records identified that they sustained a fall that required medical intervention. Review of the resident's Minimum Data Set (MDS) documentation, indicated that coding for a significant change in status assessment had been conducted. The resident was coded as having a decline over the last 90 days, in activities of daily living (ADL's). Review of the Ministry of Long-Term Care Homes (MLTCH) portal, identified that a CIS had not been submitted to the Director for this incident.

During an interview with the DRC, they indicated the home had not submitted the CIS for the incident.The MLTC Inspector reviewed with the DRC the above information as well as assessments identifying a significant change in the resident's health condition that the licensee was obligated to inform the Director within three business days.

Sources: CIS report, resident plan of care and MDS-RAI assessments, interview with the DRC. [s. 107. (3.1)]

Issued on this 14th day of December, 2020

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

Original report signed by the inspector.