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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
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Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 16, 2021	2021_661683_0007	004840-21, 006724-21, 007591-21	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 Catherines ON L2N 1L5

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

LISA BOS (683)

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): June 4, 7, 8 and 9, 2021.

The following intakes were completed during this complaint inspection:

Log #004840-21 was related to falls prevention and management;
Log #006724-21 was related to an unexpected death; and
Log #007591-21 was related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Associate Director of Resident Care (ADRC), Building Supervisor, registered staff, Personal Support Workers (PSWs), residents and families.

During the course of the inspection, the Inspector(s) toured the home, observed the provision of care, infection prevention and control practices and reviewed clinical health records, internal investigation records, relevant home policies and procedures, training records and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 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	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 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 has failed to ensure that a Personal Support Worker (PSW) used safe positioning techniques while assisting a resident.

As per the Critical Incident (CI) report and the home's internal investigation notes, a PSW provided care to a resident and an incident occurred which resulted in a significant change in their health status.

During the home's investigation, the PSW described the position the resident was left in, which was not consistent with their care plan. They reported that they did not know the resident's care plan, although they were familiar with where to find the information. The registered staff who responded to the incident also reported the unsafe position.

The Director of Resident Care (DRC) acknowledged that the resident was left in an unsafe position by the PSW.

The resident experienced a significant change in status after the PSW failed to ensure they were in a safe position.

Sources: Complaint and critical incident (CI) reports; the home's investigation notes; interview with the DRC. [s. 36.]

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

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 has failed to ensure that the written plan of care for two residents set out their planned care.

A) A resident sustained a fall which resulted in a significant change in status.

A PSW reported that they were made aware of resident care needs through reviewing their care plans.

i) The resident’s progress notes suggested that a specific falls prevention intervention was in place, but the intervention was not added to their written plan of care until several months later.

Two PSWs reported that the resident required the fall prevention intervention and confirmed that it was in place prior to the date that their written plan of care was updated.

The DRC reviewed the resident's written plan of care and acknowledged that it was not updated to reflect their use of the fall prevention intervention until the specified date, and that it should have been updated when the intervention was first initiated.

ii) The resident sustained a fall and in the post fall assessment, the registered staff selected an intervention to be implemented maintain a safe environment for the resident.

The resident's written plan of care was reviewed, and the intervention was not added until the next day.

Two PSWs indicated the intervention was in place prior to the date of their fall. The DRC acknowledged that when selecting the intervention in the post fall assessment, the registered staff member should have gone into the resident's written plan of care and added the intervention there.

The planned care for the resident was included in the progress notes or other areas of the clinical record; however, was not set out in the written plan of care which all staff were able to access.

By not updating the resident's written plan of care to reflect their use of the fall prevention interventions, there was a risk that the interventions would not be implemented.

Sources: A resident’s clinical record; interview with PSWs and the DRC.

B) A resident’s written plan of care indicated that they were at a risk for falls. They were observed with a fall prevention intervention in place, but their written plan of care did not indicate that it was required.

The resident's clinical record indicated that the intervention had been in place for just over two months.

The DRC acknowledged that the resident required the fall prevention intervention and that it was included in an area of their clinical record, but not in their written plan of care.

The planned care for the resident was included in areas of their clinical record; however, was not set out in the written plan of care which all staff were able to access.

Sources: A resident’s clinical record; interview with the DRC. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to them as specified in the plan.

A PSW provided care to a resident and an incident occurred which resulted in a significant change in their health status.

The resident’s written plan of care indicated the level of assistance they required with care. The home’s investigation notes indicated that on the date of the incident, a PSW

did not provide the appropriate level of assistance to the resident. The PSW reported that they did not know the resident's care plan, although they were familiar with where to find the information.

The DRC acknowledged that the PSW did not follow the resident's plan of care.

By not implementing an intervention in the resident's plan of care, the PSW put the resident at risk of sustaining an injury.

Sources: Complaint and critical incident (CI) reports; the home's internal investigation notes, interview with the DRC. [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 ensure that there is a written plan of care for each resident that sets out the planned care for the resident and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature was measured and documented in writing at a minimum, in at least two residents bedrooms in different parts of the home and one resident common area on every floor of the home at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The home's temperature logs were reviewed for a period of three days.

On the first day, temperature checks were completed for three resident rooms on the same home area in the morning, and only one resident room was checked in the afternoon and evening/night. Temperature checks were only completed in one common area in the morning and were not completed in the evening/night.

On the second day, temperature checks were completed for one resident room in the morning and evening/night and temperature checks were not completed in resident common areas in the morning and afternoon.

On the third day, temperature checks were completed for two resident rooms on the same home area in the morning, and only one resident room was checked in the afternoon and evening/night. Temperature checks were not completed in resident common areas in the morning or evening/night.

The Administrator acknowledged that temperature checks were being completed on a regular basis, however; there was a misunderstanding regarding the frequency of the temperature checks while interpreting the legislation.

By not recording temperatures in at least two resident bedrooms in different parts of the home and one resident common area on every floor of the home as per required frequencies there was risk that inappropriate temperatures may not have been identified.

Sources: Temperature logs; interview with the Administrator [s. 21. (3)]

Issued on this 16th day of June, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	LISA BOS (683)
Inspection No. / No de l’inspection :	2021_661683_0007
Log No. / No de registre :	004840-21, 006724-21, 007591-21
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 16, 2021
Licensee / Titulaire de permis :	The Regional Municipality of Niagara 1815 Sir Isaac Brock Way, Thorold, ON, L2V-4T7
LTC Home / Foyer de SLD :	Linhaven 403 Ontario Street, St Catherines, ON, L2N-1L5
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Cindy Perrodou

To The Regional Municipality of Niagara, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee must comply with s. 36 of O. Reg. 79/10.

Specifically, the licensee must:
1. Ensure that residents who are at risk of falls are left in a safe position.

Grounds / Motifs :

1. The licensee has failed to ensure that a Personal Support Worker (PSW) used safe positioning techniques while assisting a resident.

As per the Critical Incident (CI) report and the home's internal investigation notes, a PSW provided care to a resident and an incident occurred which resulted in a significant change in their health status.

During the home's investigation, the PSW described the position the resident was left in, which was not consistent with their care plan. They reported that they did not know the resident's care plan, although they were familiar with where to find the information. The registered staff who responded to the incident also reported the unsafe position.

The Director of Resident Care (DRC) acknowledged that the resident was left in an unsafe position by the PSW.

The resident experienced a significant change in status after the PSW failed to ensure they were in a safe position.

Sources: Complaint and critical incident (CI) reports; the home's investigation notes; interview with the DRC.

An order was made by taking the following factors into account:

Severity: A PSW left the resident in an unsafe position and they sustained serious injuries.

Scope: This was an isolated case as no other incidents of unsafe positioning were identified during this inspection.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg. 79/10, s. 36 and one Voluntary Plan of Correction (VPC) was issued to the home. (683)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jul 16, 2021

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 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère 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 16th day of June, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Bos

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