Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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
Jan 11, 2022	2021_820130_0013	010971-21, 010994-21, 011992-21, 019609-21	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

GILLIAN HUNTER (130), ROSEANNE WESTERN (508)

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): December 20, 21, 22, 23, 24, January 4, 5, 7, 2021.

During this inspection the home was toured, meal service was observed, residents and staff were observed. Clinical records, investigation files and relevant policies and procedures were reviewed.

This inspection was conducted related to the following intakes:

Log # 010971-21 related to prevention of abuse, resident care, Residents' Bill of Rights, reporting, training, supplies and equipment and housekeeping;
Log # 010994-21 related to admission and discharge;
Log # 011992-21 related to staffing, continence care, skin and wound, supplies and equipment, communication and response system; and
Log # 019609-21 related to falls management and prevention.

Please note: This inspection was conducted concurrently with the following Critical Incident Inspection: 2021_820130_0014 and Follow up inspection: 2021_820130_0012.

During the course of the inspection, the inspector(s) spoke with the Administrator, Associate Administrator, Director of Resident Care (DRC), Associated Director of Resident Care (ADOC), Occupational Therapist (OT), Registered staff, personal support workers (PSWs), Environmental Services Manager, housekeepers, residents, families and visitors.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Admission and Discharge
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

2 WN(s)
1 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 comply with s. 24 (1) 2. in that a person who had reasonable grounds to suspect abuse of a resident, failed to report the alleged abuse immediately to the Director in accordance with s. 24 (1) 2 of the LTCHA. Pursuant to s. 152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

In July 2021, a student PSW was assigned to a specified unit in the home, under the supervision of a PSW. During a shift, the student alleged they witnessed abuse of residents by the supervising PSW. In an interview, the student confirmed they did not immediately report their concerns to the home, but waited until the shift ended and later reported their concerns to their Instructor.

The ADRC confirmed they were not immediately made aware of the allegations of abuse.

One day after the alleged abuse, the ADRC received an email regarding allegations of staff to resident abuse from the students Instructor. The following day, the DRC received a second email with additional allegations of staff to resident abuse from the student.

ADRC #104 confirmed the allegations of abuse were not reported to the Director.

There was a risk of ongoing abuse of residents, when the student PSW failed to immediately report allegations of staff to resident abuse.

Sources: Staff interviews, observations, clinical records and investigation notes. [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 that a person who has reasonable grounds to suspect abuse of a resident, immediately reports their suspicions and the information upon which it is based to the Director in accordance with s. 24 (1) of the LTCHA, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that following a review of the assessments and information provided, that they approved an applicant's admission to the home unless, the home lacked the physical facilities necessary to meet the applicant's care requirements or the staff of the home lacked the nursing expertise necessary to meet the applicant's care requirements.

In June 2021, an applicant's Substitute Decision Maker (SDM) received a letter from the home, which stated that after reviewing the applicant's application for admission, the home determined they lacked the nursing expertise to manage the responsive behaviours of the applicant and they were therefore denied their admission.

The bed refusal letter and the DRC had not identified acceptable grounds for withholding approval for the applicant's admission.

Sources: Review of bed refusal letter and discussion with SDM and interview with Associate Administrator and DRC. [s. 44. (7)]

Issued on this 27th day of January, 2022

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

Original report signed by the inspector.