Ontario

**Inspection Report Under the**
**Fixing Long-Term Care Act, 2021**

**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**Hamilton District**
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
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# Original Public Report

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| **Report Issue Date:** June 27, 2024 | |
| **Inspection Number:** 2024-1567-0002 | |
| **Inspection Type:**<br>Critical Incident | |
| **Licensee:** The Regional Municipality of Niagara | |
| **Long Term Care Home and City:** Linhaven, St Catherines | |
| **Lead Inspector**<br>Erika Reaman (000764) | **Inspector Digital Signature** |
| **Additional Inspector(s)** | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 28-31, and June 3-4, 2024

The following intake(s) were inspected:

- Intake: #00103474 – Critical Incident (CI) #M551-000027-23- Falls Prevention and Management
- Intake: #00113295 – CI #M551-000004-24 – Infection prevention and control.

The following intakes were completed:

- Intake: #00115838 – CI #M551-000005-24; Intake: #00116878 – CI #M551-000006-24 were all related to infection prevention and control.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

# INSPECTION RESULTS

## Non-Compliance Remedied

**Non-compliance** was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
**Non-compliance with: O. Reg. 246/22, s. 20 (a)**
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed, and used by residents, staff and visitors at all times.

**Rationale and Summary**
On a day in May 2024, a resident sitting area located in a home area was observed to not have an easily accessible call bell. The call bell unit was located on the wall behind a chair without a call bell cord attached to it.

Staff identified that residents using the room could not easily access the call bell if there was a need for them to alert staff while in the room.

Administrator identified that the chair in the room had been moved from in front of the call bell unit and a sign placed above the unit to assist resident with locating the call bell unit.

**Sources:** Observation of home area, Interview with staff and Administrator. [000764]

Date Remedy Implemented: June 4, 2024.

## WRITTEN NOTIFICATION: Home to be Safe, Secure Environment

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 5**
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee has failed to ensure that the home is a safe and secure environment for its residents.

**Rationale and Summary**
On a date in December 2023 a resident sustained a fall with injury. The resident stated that the doors of a resident area hit them and caused them to fall. Staff indicated that after the resident had fallen the automatic door opener (button) was disabled, in order to prevent a reoccurrence. An observation of the area on a day in May 2024, showed the entrance to the resident area having two doors that when

pushed started to close quickly and were heavy which was a risk to resident safety.

An interview with staff acknowledged that the doors were not safe for residents.

As a result of the incident with the resident and the door, the maintenance team assessed the door on a date in December 2023 and determined that the fire department would need to be consulted regarding removal of the doors. At the time of the inspection the fire department had not been in to provide guidance if the doors to the sitting area could be removed. The Administrator indicated that they would be coming in the following week to assess the doors for removal.

Failure of the home to ensure that this resident sitting area was safe caused actual harm to a resident.

**Sources:** A resident's clinical records, Observation home area, Interview with staff, Review of maintenance record, Review of Critical Incident. [000764]