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

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Public Report

Report Issue Date: December 30, 2024

Inspection Number: 2024-1567-0005

Inspection Type:
Critical Incident

Licensee: The Regional Municipality of Niagara

Long Term Care Home and City: Linhaven, St Catherines

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 11-13 and December 17-19, 2024

The following intake(s) were inspected:

- Intake: #00124582 - Infectious disease outbreak.
- Intake: #00127402 - Infectious disease outbreak.
- Intake: #00128851 - Injury to resident unknown cause.
- Intake: #00130106 - Fall of resident resulting in injury.

The following intake(s) were completed:

- Intake: #00120714 - Fall of resident resulting in injury.
- Intake: #00124926 - Fall of resident resulting in injury.
- Intake: #00129000 - Fall of resident resulting in injury.
- Intake: #00132397 - Fall of resident resulting in injury.

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when their activities of daily living (ADL's) care needs changed.

Rationale and Summary
Review of the resident's clinical records and a Critical Incident (CI) report indicated that on a specified date, the resident was unable to stand and bear weight and verbalized complaints of pain. The resident was transferred to hospital and had sustained an injury. The resident also exhibited responsive behaviours, and this had not been reviewed and revised when the resident's care needs changed.

The Responsive Behaviour Support Specialist (RBSS) confirmed the resident's plan of care had not been reviewed and revised when their care needs changed.

When the plan of care had not been reviewed and revised when the resident's care needs changed, this placed the resident at a potential risk for further harm and discomfort.

Sources: CI report; resident's plan of care including their care plan, progress notes

and interviews with the RBSS.

WRITTEN NOTIFICATION: Housekeeping

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(iii) contact surfaces;

As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee has failed to ensure that procedures were developed and implemented for cleaning and disinfection of contact surfaces using at a minimum, a low level disinfectant in accordance with evidence-based practices.

Rationale and Summary
A housekeeper was observed cleaning a resident's room. The housekeeper was observed to be using a cleaner and not a low-level disinfectant on contact surfaces in a resident's room. During an interview the housekeeper identified that they use the cleaner on high touch surfaces such as handrails as well when cleaning these which are located outside of residents' rooms.

The licensee's procedure for cleaning and disinfecting surfaces directed staff when cleaning resident's rooms to use a disinfectant on high touch surfaces solely during

suspected or confirmed infectious disease outbreaks. The licensee's procedure was not developed in accordance with evidence-based practices from Public Health Ontario, which requires that all high touch surfaces are cleaned at a minimum of daily, using a low level disinfectant.

Failure to ensure that high touch surfaces in resident rooms were cleaned and disinfected using a low level disinfectant led to risk of spreading of infectious diseases.

Sources: Observation of housekeeper, Interview with housekeeper, Interview with IPAC lead, The home's policy titled "Cleaning and Disinfection of Resident's Rooms and Common Areas", The home's policy titled "Cleaning Resident's Rooms Daily-No Infection", Provincial Infectious Disease Advisory Committee (PIDA): Best Practices for Environmental Cleaning for Infection Prevention and Control.