Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 1, 2013	2013_105130_0004	H-000507-12	Complaint

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD, THOROLD, ON, L2V-4T7

Long-Term Care Home/Foyer de soins de longue durée

LINHAVEN
403 Ontario Street, St. Catharines, ON, L2N-1L5

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

GILLIAN TRACEY (130)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 10, 18, & 21, 2013

This complaint inspection was conducted simultaneously with H-001447-12 and H-000440-12.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Resident Care, Associate Director of Care and Registered Staff.

During the course of the inspection, the inspector(s) Interviewed staff, reviewed clinical records and policies and procedures and observed residents related to H -00507-12/H-001447-12/H-000440-12.

The following Inspection Protocols were used during this inspection: Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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, ss. 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, ss. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 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, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee did not ensure that any person who had reasonable grounds to suspect that 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, immediately reported the suspicion and the information upon which it was based to the Director. In 2012, Resident #1 reported an incident of rough treatment by staff, which resulted in injury. Staff did not report the incident to the Director of Resident Care until a number of days later, at which time the home submitted a critical incident report. The resident reported a second incident of rough treatment resulting in injury, by staff in 2012, Staff interviewed confirmed that this incident was not reported to the Director as required. (PLEASE NOTE: This area of non-compliance was found during Inspection #2012_105130_0005) [s. 24. (1)]

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an indep

Findings/Faits saillants :

1. The licensee did not ensure that every resident was properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. In 2012, Resident #1 voiced complaints that two identified staff members were rough during treatment. The resident had visible, unexplained injuries to the extremities. One staff member admitted rough treatment and was apologetic about the care provided, however, the other incident was not verified. The resident required a gentler approach to care, for reasons identified in the plan of care. [s. 3. (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 every resident is properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the written policy to promote zero tolerance of abuse and neglect of residents, was complied with. According to the home's policy and procedure: INDEX NO: A010618 Abuse and Neglect Zero Tolerance:
1. Staff must immediately report all alleged, suspected or witnessed incidents of:
(a) Abuse of a resident by anyone, and
(b) Neglect of a resident by staff member of the home
4. The staff of the Home will ensure that it takes appropriate action in response to any alleged, witnessed, or unwitnessed incident of resident abuse or neglect as outlined in the procedures in Appendix E - Actions to Be Taken by Staff Role and Responsibilities.
- A report of an alleged or witnessed incident of abuse or neglect must be reported to the Director of Resident Care, Administrator, or designate,
-The substitute decision maker (SDM), if any, or any other person specified by the resident must be notified immediately upon becoming aware of the incident that has resulted in physical injury or neglect of the resident that could be detrimental to the resident's health or well-being.

In 2012, Resident #1 reported an incident that an identified staff member was rough during care, which resulted in injury. The resident's injury was not assessed by a registered staff member for a number of days later. The substitute decision maker (SDM) was not made aware of the incident for a number of days after the incident was first reported. The Director of Resident Care (DRC) nor the Director were informed until several days after the incident. This information was verified by statements made by staff and records reviewed. The same resident reported a second incident later in 2012, stating rough treatment from another identified staff, during care. The resident again sustained injuries as a result of the treatment. The Director of Resident Care verified this incident was not investigated at the request of the resident. (PLEASE NOTE: This area of non-compliance was found during Inspection #2012_105130_0005) [s. 20. (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 any plan, policy, protocol, procedure, strategy or system implemented is complied with, to be implemented voluntarily.

Issued on this 1st day of February, 2013

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

Ontario

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Issued on this 1st day of February, 2013

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

Gillian Tracey.