Ontario

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

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: November 3, 2023
Inspection Number: 2023-1567-0004
Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: The Regional Municipality of Niagara
Long Term Care Home and City: Linhaven, St Catherines

Lead Inspector	**Inspector Digital Signature**
Stephanie Smith (740738)	

Additional Inspector(s)
Klarizze Rozal (740765)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 19-20 and 23-25, 2023.

The following intake(s) were inspected:

- Intake: #00096347 - for a Follow-up #: 1 - High Priority Compliance Order (CO) #001 / 2023-1567-0003, LTCHA, 2007 S.O. 2007, c.8 - s. 19 (1) Duty to Protect, Compliance Due Date (CDD) October 19, 2023.
- Intake: #00096434 - for a Complaint related to concerns with staffing, prevention of abuse and neglect, responsive behaviours, and falls prevention and management.
- Intake: #00096348 - for Critical Incident (CI) (M551-000017-23) related to falls prevention and management, hospitalization, and unexpected death.
- Intake: #00098903 - for a CI (M551-000023-23) related to falls prevention and management.
- Intake: #00096545 - for a CI (M551-000019-23) to falls prevention and management.
- The following intake(s) were completed in this inspection: Intake: #00097628 CI (M551-000022-23) related to falls prevention and management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1567-0003 related to LTCHA, 2007 S.O. 2007, c.8, s. 19 (1) inspected by Stephanie Smith (740738)

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
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)
O. Reg. 246/22, s. 58 (1) 1.

The licensee has failed to ensure that a resident's identified triggers of their responsive behaviours were developed and written.

In accordance with O. Reg 246/22, s. 11(1)(b) the licensee is required to ensure that the home's Responsive Behaviour Program was fully implemented and complied with. Specifically, to ensure triggers to a resident's responsive behaviours were identified and written in their care plan.

Rationale and Summary
A resident's clinical records identified their triggers for their responsive behaviours in various progress notes, behavioural alerts, and tips and trick sheets. The resident’s identified behavioural triggers were not written in their care plan. On a specified date in October 2023, A Programs Manager (PM) acknowledged the resident's care plan under their responsive behaviours did not indicate their triggers as per the home’s policy. On the same day, the care plan was revised and updated with the identified behavioural triggers.

Sources: A resident's clinical records, Responsive Behaviour Program, and an interview with a PM.

Date Remedy Implemented: October 23, 2023 [740765]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs changed.

Rationale and Summary
A resident was moved to another unit at the home on a specified date in March 2023. They experienced several falls on the unit between March 2023 and September 2023. On a specified date in September 2023, the resident fell and sustained an injury. The day after the fall, the care plan, which was part of the resident's plan of care, was updated to include an intervention.

An Associate Director of Care (ADRC) acknowledged that this intervention should have been included in the care plan prior to the resident's September 2023 fall.

Failure to ensure that the plan of care was revised when a resident's care needs changed related to falls, put the resident at risk for injury from falls.

Sources: A resident's care plan, interview with an ADRC and other staff. [740738]

WRITTEN NOTIFICATION: Reporting Matters to the Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that when a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident resulted in harm or risk of harm to the resident shall immediately report this suspicion to the Director.

Rationale and Summary
A complaint was lodged regarding alleged abuse by a resident to co-residents. The resident's clinical records

between February to May 2023, indicated multiple behavioural incidents by a resident to co-residents. Multiple staff indicated the incidents were of non-consensual by a resident towards the co-residents and that these incidents were reported to Management. Staff acknowledged any alleged abuse should be reported immediately.

An ADRC acknowledged they did not report the incidents to the Director. They acknowledged the incidents between a resident and co-residents had potential risks for harm and negative impact.

Failure to report incidents of alleged abuse immediately to the Director, put the residents at risk for harm and abuse.

Sources: Residents' clinical records, Mandatory Reporting and Critical Incidents Reporting Requirements Policy, interviews with staff. [740765]

WRITTEN NOTIFICATION: Communication and response system

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (f)

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that clearly indicates when activated where the signal is coming from for a resident.

Rationale and Summary
On a specified date in October 2023, a resident was observed in their room, sitting in a chair near the doorway. The resident's call bell was placed on their bed and they were unable to reach it. A Personal Support Worker (PSW) and the resident confirmed that the resident was given a metal bell to ring for help because the call bell, which was attached to the wall, could not reach the resident where they were sitting.

On a later date in October 2023, the resident was observed to have a whistle around their neck and informed Inspector 740738 that this was to be used to call for help.

An ADRC acknowledged that neither call bell intervention was connected to the home's resident-staff communication response system.

Failure to ensure that the home's resident-staff communication and response system clearly indicated where the signal was coming from, put the resident at risk of not receiving help when needed.

Sources: Observations, interviews with a resident, a PSW, and an ADRC. [740738]

COMPLIANCE ORDER CO #001 Duty to Protect

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:

1. Educate all staff working on a specified unit and all of Management on the LTCH's policies of Abuse and Neglect- Zero Tolerance and the Mandatory Reporting and Critical Incidents Reporting Requirements. Specifically, highlighting the definition of sexual abuse.
2. Maintain written records of the education provided and the list of staff who received and completed the education. All written records must be available on request.

Grounds

The licensee has failed to ensure that residents were protected from sexual abuse by a resident.

According to O. Reg. 246/22 s. 2 (1) defines sexual abuse under (b) as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Rationale and Summary
A complaint was lodged regarding alleged sexual abuse by a resident to co-residents.

A resident's clinical records indicated incidents with sexual inhibitions towards co-residents. A review of progress notes from February to May 2023, specified the resident touching co-residents:

1. On a specified date in February 2023, a resident was observed grabbing another resident in a sexual nature and a staff member heard the resident asking for the other resident to stop. Staff intervened and the resident was re-directed.
2. On a specified date in March 2023, a resident was witnessed touching another resident in a sexual nature. The residents were both separated. A Recreationist stated that the affected resident was observed upset after the incident.
3. On a specified date in March 2023, a resident was witnessed grabbing another resident in a sexual nature. Staff intervened and re-directed the resident. Notes indicated that the other resident required reassurance by staff after the incident.
4. On a specified date in April 2023, a resident was found touching another resident in a sexual nature. The affected resident was observed upset and was closed in between a table and a chair, unable to leave the situation. Registered staff were called to assist with intervention.

After these noted incidents, the home implemented additional interventions for the resident.

Notes from May 2023, and documented by the Nurse Practitioner (NP), indicated that the resident nor the co-residents had the cognitive capacity to consent to the resident's touching. Multiple staff acknowledged the incidents between the resident and co-residents were non-consensual touching and behaviours of sexual nature and met the home's definition of sexual abuse.

Two registered staff indicated the incidents had been reported to Management when they occurred. A PM and an ADRC acknowledged the incidents between the resident and co-residents had potential risks for harm and negative impact for sexual abuse. They did not report any of the incidents to the Director.

Failure to protect residents from sexual abuse by a resident, put the residents at risk for harm.

Sources: Residents' clinical records, Abuse and Neglect- Zero Tolerance Policy, Mandatory Reporting and Critical Incidents Reporting Requirements Policy, interviews with staff. [740765]

This order must be complied with by January 31, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001

Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By

submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing

(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.