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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 22, 2015	2015_188168_0016	H-001950-15	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

LISA VINK (168)

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): June 17 and 18, 2015.

This inspection was conducted concurrently with Critical Incident Inspection H-002028-15, inspection number 2015-188168-0017.

A finding of non compliance related to the concurrent inspection is included in this Inspection Report, related to LTCHA s. 6(1) plan of care.

During the course of the inspection, the inspector(s) spoke with the Administrator, former Director of Nursing, Physiotherapist, the Director of Senior Services, registered nursing staff, personal support workers and residents.

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

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	Legendé 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A. According to the clinical records residents #10 and #11 both had cognitive decline and impaired abilities to make decisions. It was identified that for approximately two and a half months in 2014, the two residents were repeatedly observed spending time together and at times observed to be hand holding and/or kissing. This behaviour was undesired by the Power of Attorney (POA) for one of the identified residents, who voiced concerns for the resident's safety and security. Staff interviewed confirmed that they were instructed to monitor the residents and make efforts to keep them separated and at one time even had one to one staff in place to assist in this task. A review of the plans of care for both residents did not include any plans or interventions to keep the two residents separated and prevent them from spending close proximity time together. Staff interviewed and progress notes confirmed that increased monitoring was part of the planned care for both residents in an effort to manage the situation; however, that this information was not included in their plans of care.

B. According to the clinical records residents #12 and #13 both had cognitive decline and impaired abilities to make decisions. On February 17, 2015, the two residents were found by staff in a compromised situation and although neither resident was upset or sustained harm staff took immediate action to separate them. Staff documented the incident and recorded in the progress notes that a plan would be developed to prevent recurrence. A review of the plans of care for both residents did not include the incident nor a plan/interventions to prevent recurrence. Staff interviewed and progress notes confirmed that increased monitoring was part of the planned care for both residents in an effort to manage the situation; however, that this information was not included in their plans of care. [s. 6. (1) (a)]

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 written plan of care for each resident sets out the planned care for the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a written complaint received concerning the care of a resident or the operation of the long-term care home was immediately forwarded to the Director.

The POA for resident #10 contacted the office of their Member of Provincial Parliament (MPP) and voiced concerns regarding the treatment of the resident at the long term care home. The MPP's staff wrote a letter dated April 21, 2015, to the Director of Senior Services, on behalf of the POA, which indicated the POA's request to have a meeting to discuss the concerns. The Director of Senior Services and Administrator confirmed that the letter was received and actions were taken to address the concerns including, but not limited to, a number of phone and face to face conversations. The Director of Senior Services also confirmed that the letter was not forwarded to the Director of the Ministry of Health and Long Term Care, based on a number of factors. [s. 22. (1)]

Issued on this 22nd day of June, 2015

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

Original report signed by the inspector.