



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**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**

**Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905)-546-8255**

**Bureau régional de services de
Hamilton
119, rue King Ouest, 11^{ième} étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255**

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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
Jun 5, 2013	2013_201167_0017	H-000295- 13	Critical Incident System

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

MARILYN TONE (167)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 31 and June 5, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, the Assistant Director of Care, staff who may have had knowledge of the alleged incident and the identified resident.

During the course of the inspection, the inspector(s) conducted a review of the identified resident's health file, relevant policies and procedures and investigation notes completed by the home related to the alleged incident.

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



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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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :



1. The licensee did not ensure that staff and others involved in the different aspects of care of the resident collaborate with each other, b) in the development of the resident's plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

A) The plans of care for resident # 001 directed staff to provide extensive assistance with the sit to stand lift and two staff for toileting the resident. The plans of care also indicated that the resident may require the use of a sling lift occasionally.

B) The Quarterly Resident Assessment Protocol indicated that the resident's transfers have been addressed by the Lift and Transfer Committee, Physiotherapist, and the resident had also vocalized complained of pain and discomfort with use of the mechanical sling lift. The assessment indicated that the resident was unable to safely transfer on the sit to stand lift as they would slide down through the sheepskin transferring belt.

C) The Transfer and Positioning assessment in the assessment section of the electronic documentation system indicated that resident # 001 could lift their legs in and out of bed, stand, had poor balance, full weight bearing. Was able to ambulate with assistance and/or walking aid. Therefore NO LIFT NEEDED - 2 Person extensive assistance.

D) A transfer Logo found on the wall beside the resident's bed directed staff to use two staff side to side assistance for transfers with no indication of the need for mechanical lifting devices.

E) Staff interviewed indicated that the resident was being transferred using two staff side by side transfer but recently the resident had allowed staff to transfer them using the sit to stand lift and two person assistance. Staff interviewed confirmed that two staff are required for all transfers with a mechanical lift.

The assessments completed, the plan of care, the transfer logo in the resident's room and staff responses during interviews provided conflicting information related to how the resident was to be toileted. Staff and others did not collaborate in the development of the resident's plan of care related to toileting. [s. 6. (4) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".



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WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. Resident # 001 was not transferred by a staff member using safe transferring and positioning techniques.

A) The plan of care for resident # 001 indicated that the resident required extensive assistance for toileting with the sit to stand lift and two staff assistance.

B) Staff interviewed indicated that the resident requires two staff to assist with transfers.

C) The resident complained of discomfort after reporting that they had sustained an injury during the transfer with one staff member.

D) The transfer logo in the resident's room directed staff to use two persons when transferring the resident.

D) An identified staff member admitted that they had transferred the resident without the assistance of a second staff member.

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.



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Long-Term Care

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Issued on this 2nd day of July, 2013

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

Marilyn Lone



Ministry of Health and
Long-Term Care

Ministère de la Santé et
des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : MARILYN TONE (167)

Inspection No. /

No de l'inspection : 2013_201167_0017

Log No. /

Registre no: H-000295-13

Type of Inspection /

Genre d'inspection: Critical Incident System

Report Date(s) /

Date(s) du Rapport : Jun 5, 2013

Licensee /

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

LTC Home /

Foyer de SLD : LINHAVEN
403 Ontario Street, St. Catharines, ON, L2N-1L5

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : May Simpson

To THE REGIONAL MUNICIPALITY OF NIAGARA, you are hereby required to
comply with the following order(s) by the date(s) set out below:



Ministry of Health and
Long-Term Care

Ministère de la Santé et
des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou
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Order # / Ordre no : 001	Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)
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Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to demonstrate how the home will ensure that staff and others involved in different aspects of care of the resident collaborate with each other in the development of the resident's plan of care so that the different aspects of care are integrated and consistent with each other.

The plan shall be submitted electronically to Marilyn Tone, Long Term Care Homes Inspector, Ministry of Health and Long Term Care at Marilyn.Tone@ontario.ca by the end of the business day June 18, 2013.

Grounds / Motifs :



**Ministry of Health and
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Order(s) of the Inspector
Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007*, S.O. 2007, c.8

**Ministère de la Santé et
des Soins de longue durée**

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou
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de soins de longue durée*, L.O. 2007, chap. 8

1. [LTCHA, 2007,S.O. 2007,c.8, s.6(10)b was previously issued May 12, 2011 as VPC and s. 6(1)c was previously issued April 18, 2012 as WN]

A) The plans of care for resident # 001 directed staff to provide extensive assistance with the sit to stand lift and two staff for toileting the resident. The plans of care also indicated that the resident may require the use of a sling lift occasionally.

B) The Quarterly Resident Assessment Protocol indicated that the resident's transfers have been addressed by the Lift and Transfer Committee, Physiotherapist, and indicated that the resident had also vocalized complaints of pain and discomfort with the use of the mechanical sling lift. The assessment indicated that the resident was unable to safely transfer with the sit to stand lift as they would slide down through the sheepskin transferring belt.

C) The Transfer and Positioning assessment in the assessment section of the electronic documentation system indicated that resident # 001 could lift their legs in and out of bed, stand, had poor balance, full weight bearing and was able to ambulate with assistance and/or walking aid. Therefore "NO LIFT NEEDED" - 2 Person extensive assistance.

D) A transfer logo found on the wall beside the resident's bed directed staff to use two staff side to side assistance for transfers with no indication of the need for mechanical lifting devices.

E) Staff interviewed indicated that the resident was being transferred using two staff side by side transfer but recently the resident had allowed staff to transfer them using the sit to stand lift and two person assistance. Staff interviewed confirmed that two staff are required for all transfers with a mechanical lift. The completed assessments, the plan of care, the transfer logo in the resident's room and staff responses during interviews provided conflicting information related to how the resident was to be toileted. Staff and others did not collaborate in the development of the resident's plan of care related to toileting.

(167)



**Ministry of Health and
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Order(s) of the Inspector
Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007*, S.O. 2007, c.8

**Ministère de la Santé et
des Soins de longue durée**

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou
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**This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :**

Jul 14, 2014



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section 154 of the *Long-Term Care
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**Ministère de la Santé et
des Soins de longue durée**

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou
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REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603



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Order(s) of the Inspector

Pursuant to section 153 and/or
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Homes Act, 2007*, S.O. 2007, c.8

**Ministère de la Santé et
des Soins de longue durée**

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Aux termes de l'article 153 et/ou
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de soins de longue durée*, L.O. 2007, chap. 8

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance
Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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



Ministry of Health and
Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or
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Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et
des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou
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de soins de longue durée*, L.O. 2007, chap. 8

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis:

La demande de réexamen doit contenir ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le titulaire de permis souhaite que le directeur examine;
- c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.



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Long-Term Care**

Order(s) of the Inspector
Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007*, S.O. 2007, c.8

**Ministère de la Santé et
des Soins de longue durée**

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou
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de soins de longue durée*, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la
conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 5th day of June, 2013

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur :

MARILYN TONE

Service Area Office /

Bureau régional de services : Hamilton Service Area Office