



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

**Rapport d'inspection
prévus le *Loi de 2007
les foyers de soins de
longue durée***

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7

Bureau régional de services de Hamilton
119, rue King Ouest, 11^{ème} étage
Hamilton ON L8P 4Y7

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

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

Telephone: 905-546-8294
Facsimile: 905-546-8255

Téléphone: 905-546-8294
Télécopieur: 905-546-8255

☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection September 21, 2010	Inspection No/ d'inspection 2010_146_9551_21Sept110051	Type of Inspection/Genre d'inspection Critical Incident H-01106
Licensee/Titulaire 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(s) Barbara Naykalyk-Hunt, LTC Homes Inspector #146		
Inspection Summary/Sommaire d'inspection		
The purpose of this inspection was to conduct a Critical Incident inspection regarding a resident fall from suspected improper care which resulted in injury.		
During the course of the inspection, the inspector spoke with: the Administrator, the Director of Care (DOC), the Associate Director of Care (ADOC).		
During the course of the inspection, the inspector: did a health file review of the resident and reviewed the home's policy regarding bathing and showering chairs (N070401).		
The following Inspection Protocols were used during this inspection: Dignity, Choice and Privacy		
☒ Findings of Non-Compliance were found during this inspection. The following action was taken: 2 WN		

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, 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.

Findings:

1. A resident slid from a shower chair and was injured on August 27, 2010 at 1030 in the morning as a result of improper care. The Personal Support Worker attended the resident in the shower room alone and did not follow the plan of care which stated 2 persons were to bathe the resident nor did the staff person use the safety belt (as per the home's policy N070401) on the shower chair. The home did not immediately report the incident to the Director. The CIS was submitted August 30, 2010 at 1141h.

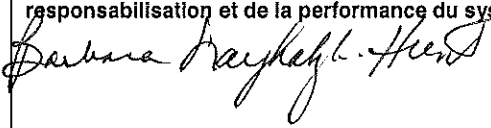
WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(7)

The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings:

1. A resident was bathed by one staff person on August 27, 2010 and sustained an injury when she fell from the chair. The care plan's directions were to use 2 staff for the resident's bath/shower.



Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné		Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. 
Title:	Date:	Date of Report: (if different from date(s) of inspection).