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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 21, 2016	2016_342611_0011	030283-15; 011736-16	Critical Incident System

Licensee/Titulaire de permis

MENNONITE BRETHREN SENIOR CITIZENS HOME
1 Tabor Drive St. Catharines ON L2N 1V9

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

MENNONITE BRETHREN SENIOR CITIZENS HOME
1 Tabor Drive St Catharines ON L2N 1V9

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

KELLY CHUCKRY (611)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 28 and 29, 2016.

This Critical Incident inspection was conducted concurrently with a follow-up inspection (inspection #2016_342611_0010). Two critical incidents were inspected upon during this inspection, and they included Log #030283-15 related to the Prevention of Abuse and Neglect, and Log # 011736-16 related to the Prevention of Abuse and Neglect, and plan of care.

During the course of the inspection, the inspector(s) spoke with residents, the Director of Operations, Director or Care (DOC), registered staff, and Personal Support Workers (PSW's).

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **1 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all residents were protected from abuse by anyone and were free from neglect by the licensee or staff in the home.

The definition of neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety, or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

On an identified date, staff #109 was providing personal care to resident #001 using an improper chair. During this care, the resident began to slide out of the chair they were sitting in. The resident was lowered to the floor. Staff #109 rang the call bell for assistance and staff #109 and staff # 103 manually lifted resident #001 off the floor and staff #109 continued with personal care.

Staff #103 reported to staff #101 that resident #001 had a near miss, as that was what was communicated to staff #103 at the time of the incident. It was further reported that the resident did not sustain an injury. A short while later, the chair began to tip and staff #109 rang the call bell for assistance a second time. Staff #103 provided assistance again, and both staff members completed the personal care for resident #001. After the care was completed, it was reported to staff #101 that resident #001 was lowered to the floor and a part of their body hit the floor. An x-ray was completed for resident #001, two days later, and confirmed that an injury was sustained during the incident.

Staff #109 failed to provide resident #001 with the care required for their safety and well-being when they provided personal care to resident #001 using an improper chair, resulting in injury to the resident. After the initial incident, staff #109 and staff #103 also failed to provide the resident with the care required for their safety and well-being when they manually lifted the resident off the floor.

An interview conducted with the Director of Operations and the Director of Care confirmed the incident occurred and staff #109 was disciplined for negligence as it related to the home's Abuse Policy.

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that they had, instituted, or otherwise had in place, any plan, policy, protocol, procedure, strategy, or system, the licensee failed to ensure that the plan, policy, protocol, procedure, strategy, or system was complied with.

A. The home had a policy in place entitled "Bathing-General Guidelines". Under the title of bathing options, this policy speaks to showering residents using a shower chair.

On an identified date, staff #109 was providing personal care to resident #001. This personal care was provided to the resident using an improper chair.

B. The home had a policy in place entitled "Falls Prevention and Management Program". Under the title Fall and Post Fall Assessment and Management, this policy indicates that the person witnessing a fall or finding the resident on the floor shall notify the registered nursing staff and keep the resident in position if there is suspicion or evidence of injury until a full head to toe assessment has been conducted.

On an identified date, resident #001 was being provided with personal care. During this personal care the resident slid out of the chair twice and was lowered to the floor on the first incident. Resident #001 hit a part of their body on the floor during this incident. Resident #001 complained of pain.

Staff #109 was providing personal care to resident #001 and rang for assistance. Staff #103 assisted staff #109 physically lift resident #001 off the floor and back onto the chair to complete the personal care. The resident was not kept in position on the floor after either incident and was not immediately assessed by a registered staff member. In addition, a mechanical lift was not used to transfer the resident off the floor, as per the home's expectation.

An interview conducted with staff #103 and #101 confirmed that it was the home's procedure to utilize a mechanical lift for residents who require assistance off the floor after a fall.

An interview conducted with the Director of Operations and the Director of Care confirmed that the home's respective policies and/or procedures were not followed in the above noted instances. [s. 8. (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 where they have instituted, or otherwise have in place, any plan, policy, protocol, procedure, strategy, or system, that the plan, policy, protocol, procedure, strategy, or system is complied with, 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 has failed to ensure that there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with.

On an identified date, staff #100 witnessed several incidences of resident abuse during a shift while working with staff #110. These witnessed incidences were not reported until the following afternoon to the Director of Care.

The home had an Abuse policy that clearly indicated when abuse is witnessed "the supervisor shall be notified by the witness immediately, who shall in turn notify the Administrator of the incident". The RN and RPN were not notified of the incidences of abuse at the time of the incidences.

An interview with the Director of Operations and the Director of Care confirmed the incidences occurred, and further confirmed the home's Abuse policy was not complied with in this instance. [s. 20. (1)]

2. A) Resident #006 had moderate to severe cognitive impairment. Staff #100 and #110 entered the room of resident #006 to provide care. Staff #100 witnessed staff #110 slap this resident in the genitals. When contact was made with the resident, this resident showed signs of discomfort.
B) Resident #004 had mild cognitive impairment. Staff #100 and #110 entered the room of resident #004 to provide care. Staff #100 witnessed staff #110 throwing a sheet over this residents head. Staff #110 laughed and verbalized they were practicing as if the resident was dead. Resident #004 moved the sheet away from their face.
C) Resident #007 had very severe cognitive impairment. Staff #100 and #110 entered the room of resident #007 to provide care. Staff #100 witnessed staff #110 put their right foot up on resident #007's bed while standing at the foot end of the bed. Staff #110 grabbed this resident by the ankles and lifted their feet in the air to change their brief. Staff #100 verbalized this action was going to hurt the resident, however staff #110 continued with the brief change.
D) Resident #002 and resident #005 both had borderline intact cognition. Both of these residents were watching a television program in a common area of the home. Staff #100 witnessed staff #110 change the channel to another program. Both resident #002 and resident #005 expressed their unhappiness with the changed channel and requested the channel be changed back. Both residents left the common area of the home not able to watch their preferred program. Staff #100 attempted to intervene without success.

The home had an Abuse policy that was in place for all departments of the home. This policy indicated that "all abuse and neglect is wrong". It further indicated that "under no circumstances and in no way will any abuse or neglect of a resident be tolerated".

The above information notes four (4) incidences of abuse. The homes' abuse policy was not complied with.

An interview with the Director of Operations and the Director of Care confirmed the incidences did occur and the home's abuse policy was not complied with. Staff #110 is no longer an employee of the home. [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 there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with, to be implemented voluntarily.

Issued on this 8th day of August, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and 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

Ministére de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY CHUCKRY (611)
Inspection No. / No de l'inspection :	2016_342611_0011
Log No. / Registre no:	030283-15; 011736-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 21, 2016
Licensee / Titulaire de permis :	MENNONITE BRETHREN SENIOR CITIZENS HOME 1 Tabor Drive, St. Catharines, ON, L2N-1V9
LTC Home / Foyer de SLD :	MENNONITE BRETHREN SENIOR CITIZENS HOME 1 Tabor Drive, St Catharines, ON, L2N-1V9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	TIM SIEMENS

To MENNONITE BRETHREN SENIOR CITIZENS HOME, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all residents are protected from abuse by anyone and to ensure safe bathing practices are followed by all staff in the home. The plan shall include
a) strategies to prevent abuse by staff towards resident #001 and any other resident,
b) staff education on abuse including dates that the education will be completed and
c) staff education of bathing policies in the home, ensuring the review of the types of acceptable bathing chairs to be used
d) staff education on the home's lift and transfer policy,
d) quality management activities (including the type of activities and frequency) that will be implemented to target the specific area of non-compliance.
The plan should be submitted via email by July 8, 2016, to Kelly Chuckry at the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 119 King St. W, 11th
floor, Hamilton, ON L8P 4Y7 HamiltonSAO.MOH@ontario.ca

Grounds / Motifs :

1. The licensee has failed to ensure that all residents were protected from abuse by anyone and were free from neglect by the licensee or staff in the home.

The definition of neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety, or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

On an identified date, staff #109 was providing personal care to resident #001 using an improper chair. During this care, the resident began to slide out of the chair they were sitting in. The resident was lowered to the floor. Staff #109 rang the call bell for assistance and staff #109 and staff # 103 manually lifted resident #001 off the floor and staff #109 continued with personal care.

Staff #103 reported to staff #101 that resident #001 had a near miss, as that was what was communicated to staff #103 at the time of the incident. It was further reported that the resident did not sustain an injury. A short while later, the chair began to tip and staff #109 rang the call bell for assistance a second time. Staff #103 provided assistance again, and both staff members completed the personal care for resident #001. After the care was completed, it was reported to staff #101 that resident #001 was lowered to the floor and a part of their body hit the floor. An x-ray was completed for resident #001, two days later, and confirmed that an injury was sustained during the incident.

Staff #109 failed to provide resident #001 with the care required for their safety and well-being when they provided personal care to resident #001 using an improper chair, resulting in injury to the resident. After the initial incident, staff #109 and staff #103 also failed to provide the resident with the care required for their safety and well-being when they manually lifted the resident off the floor.

An interview conducted with the Director of Operations and the Director of Care confirmed the incident occurred and staff #109 was disciplined for negligence as it related to the home's Abuse Policy. (611)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 01, 2016

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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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
Long-Term Care Inspections 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.

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
Inspection de soins de longue durée
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.

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
Inspection de soins de longue durée
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 21st day of June, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kelly Chuckry

Service Area Office /
Bureau régional de services : Hamilton Service Area Office