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 sions de longue durée

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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
Feb 9, 2017	2016_560632_0011	032226-16	Resident Quality Inspection

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

YULIYA FEDOTOVA (632), KERRY ABBOTT (631), ROBIN MACKIE (511)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 21, 22, 23, 24, 25, 28, 29, 30, and December 1, 2016.

During the course of the inspection, the inspector(s) toured the home, interviewed residents and family members, observed the provision of care and services, and reviewed relevant documents including but not limited to meeting minutes, policy and procedures, and clinical records.

In addition to RQI, the following inspections were completed:
1. One Critical Incident System 029806-16 related to abuse/neglect staff to resident.
2. One Follow up (CO #001) 027015-16 related to abuse/neglect staff to resident.

During the course of the inspection, the inspector(s) spoke with Registered Practical Nurses (RPNs), Registered Nurses (RNs), Health Care Aids (HCAs), Personal Support Workers (PSWs), Nutrition Manager (NM), Recreation Supervisor (RS), Resident Assessment Inventory (RAI) - Minimum Data Set (MDS) Co-ordinator, Director of Care (DOC), and Director.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 19. (1)	CO #001	2016_342611_0011	632

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 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. In accordance with Regulation, s. 30, paragraph (1), required every licensee of a long-term care home to have a written description of the program that included its goals and objectives and relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required, and s. 36, required every licensee of a long-term care home to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that 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, was complied with.
On an identified date in October, 2016, an incident occurred in which resident #026 was transferred onto the toilet and left unattended. A review of the resident's plan of care indicated that the resident was to be transferred with extensive assistance by two (2) staff.

A review of the home's policy titled, "Zero Lift Policy", on an identified date in May 2013, stated, "A resident being toileted with the aid of a mechanical lift cannot be left alone on the toilet, unless assessed and care plan states otherwise". A review of the resident's plan of care did not indicate that the resident had been assessed and could be left alone on the toilet as specified in the policy. An interview with the Director confirmed that based on the Zero Lift Policy, the resident should not have been left unattended on the toilet. [s. 8. (1) (b)]

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 any plan, policy protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written record of review of the Infection Prevention and Control Program, including the date of the evaluation, the names of the persons who participated, a summary of the changes made, and the date those changes were implemented.

On an identified date in November, 2016, DOC and the Director of the home confirmed that there was no written record of review of the Infection Prevention and Control Program, including the date of the evaluation, the names of the persons who participated, a summary of the changes made, and the date those changes were implemented. [s. 229. (2) (e)]

2. The licensee failed to ensure that all staff participate in the implementation of the program.

i) On an identified date in November, 2016, an initial tour of the home was conducted by inspector #631. During the tour in one of the tub rooms, the inspector observed the following used, unlabelled personal items: two (2) hairbrushes, four (4) deodorant sticks, one (1) barrier cream, one (1) Sudo cream.
On an identified date in November, 2016, inspector #631 observed the following used, unlabelled personal items in one of the tub rooms: three hairbrushes, two (2) deodorant sticks, one (1) barrier cream. Staff #106 confirmed that it was the expectation that personal hygiene items were labelled. (631)

ii) On November 28, 2016, there were unlabelled personal items found on the counter tops in several residents' shared bathrooms: one (1) black and green hair brush, one (1) black hair comb and two (2) tooth brushes stored in unlabelled green container. An interview with the staff identified that residents' personal items were to be labeled and stored in labelled personal bathroom cabinets. On an identified date in November, 2016, DOC indicated that the home's expectation was that personal items were to be labelled to prevent infection by cross contamination. The home's staff did not participate in the implementation of the Infection Control and Prevention Program. (632) [s. 229. (4)]

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 all staff participate in the implementation of the program,, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A review of resident #021's record indicated that on or about an identified date in July, 2016, the resident began to exhibit identified symptoms. These symptoms continued until the resident's transfer and subsequent admission to hospital on an identified date in July, 2016, where they received a diagnosis. The resident's record also indicated that during the period of an identified dates in July 2016, as well as the post discharge period of an identified dates in August, 2016 to September, 2016, the resident required a significant increase in the use of medications that were related to their symptoms.

A review of the resident's previous plan of care under focus of pain indicated that the resident experienced pain. The resident's most recent care plan was not revised to indicate the resident's significant change of status related to the resident's acute pain and subsequent interventions required to treat the resident's pain.

Inspector #631 interviewed registered staff members. Both staff confirmed that the resident experienced an increased severity of pain prior to admission to hospital on an identified date in July 2016, and post discharge from hospital on an identified date in July, 2016. Both staff confirmed that the resident's pain had since resolved; however, the pain was being treated due to a change in condition, and the care plan should have been updated. The staff stated that the home's procedure was that the registered staff were to notify another registered staff of the change and that registered staff were responsible to revise the care plan.

An interview with the staff members confirmed that an increase in the medications used to decrease pain was required for resident #021 to control pain until the medications that control pain were discontinued on an identified date in September, 2016. The staff member also confirmed that there were no changes made to the care plan to reflect pain management or goals for pain management and that the care plan should have been updated according to the resident's new order for the medications used to control pain and change in condition.

The home's "Pain Assessment and Management" policy, stated that the Registered Nursing staff were to "Monitor and evaluate the care plan at least quarterly and more frequently as required based on the resident's condition" and that "if the interventions had not been effective in managing pain, initiate alternative approaches and update as necessary". [s. 6. (10) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee of a long-term care home failed to ensure that where bed rails were used, the resident was assessed and their bed system was evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices, to minimize the risk to the resident.

i) On an identified date in November, 2016, it was observed that one quarter bed rails were used for resident #001 on the both sides of their bed. As per resident observations and staff members interviews, the resident was not physically capable of getting out of bed on their own. Staff members stated that the bed rails were used for safety. Resident's care plan intervention section stated that resident's bed mobility was total two staff, Personal Assistance Services Device (PASD): side rails up two bed rails when in bed used for safety and security. Review of clinical records indicated that there was no documented assessment for the use of the bed rails, which was confirmed by staff members on an identified date in November, 2016. (632)

ii) On an identified date in November, 2016, resident # 004 stated that they used one quarter bed rails for support on the both sides of their bed, which was confirmed by staff member. The resident required extensive assistance with two staff in bed for mobility. The resident's care plan indicated that they were able to weight bear with staff assistance of grabbing bars and side rails and the resident could hold onto side rails and follow instructions. Review of clinical records indicated that there was no documented assessment for the use of the bed rails, which was confirmed by staff members on an identified date in November, 2016. [s. 15. (1) (a)]

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained. 2007, c. 8, s. 31 (2).
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the restraining of a resident by a physical device might be included in a resident's plan of care only if all of the following satisfied:
2. Alternatives to restraining the resident had been considered, and tried where appropriate, but would not be, or had not been, effective to address the risk referred to in paragraph 1.

On an identified date in November, 2016, resident # 014 was observed sitting in their tilted wheelchair. Resident was not able physically and cognitively to release themselves from the tilted position of their tilt wheel chair. The resident's care plan indicated that they had a tilt wheelchair for long distances. Review of clinical records indicated that there was no documented assessment for the use of the tilted wheelchair, where alternatives to restraining the resident had been considered, which was confirmed by staff members on an identified date in November, 2016. [s. 31. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriated assessment instrument that was specifically designated for falls.

i) On an identified date in October, 2016, resident #014 fell out of their wheelchair with no injury. Review of the clinical records indicated that a post fall assessment was not completed for this resident by the registered staff after the fall as it was defined in Falls Prevention & Management Program, which was confirmed by staff members during the interview on an identified date in November, 2016. [s. 49. (2)]

Issued on this 13th day of February, 2017

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

Original report signed by the inspector.