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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 6, 2017	2017_575214_0022	025575-17	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

CATHY FEDIASH (214), CATHIE ROBITAILLE (536), LISA BOS (683)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 20, 21, 22, 23 and 27, 2017.

During the course of the inspection, the inspector(s) spoke with the Interim Director; Director of Care (DOC); Assistant Director of Care (ADOC); Resident Assessment Instrument (RAI) Coordinator; Nutrition Manager; Registered Dietician (RD); Maintenance Supervisor; Therapeutic Recreation Supervisor & Volunteer Coordinator; Pharmacy Liaison Staff; Registered staff; Personal Support Workers (PSW); residents and families.

During the course of this inspection, the Inspectors reviewed resident clinical records; reviewed policies and procedures; reviewed medication incidents and meeting minutes; a pharmacy audit and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **5 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 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system was complied with.

O. Reg. 79/10, s. 68 (1) (a) identifies that this section and sections 69 to 79 apply to the organized program of nutrition care and dietary services required under clause 11 (1) (a) of the Act, which identifies that every licensee of a long-term care home shall ensure that there is an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents.

A review of the home's policy titled "Weight & Height Measurement," last reviewed February 2017, indicated the following:

i) Any resident exhibiting a weight fluctuation of (or more than) 5 per cent (%) (or 2 kilograms (kg) or more) of the resident's body weight in one month shall be reweighed immediately.
ii) The Registered Dietitian assesses each resident with a significant weight change/decrease, makes appropriate recommendations to physicians, staff and updates the resident's care plan in collaboration with the Registered staff.

A) Resident #002's clinical record identified that they were on a specified diet and texture. The resident's weights on two specified dates, one month apart were identified to represent a weight loss of 4.4 kg and 5.6 % over one month.

Interview with the RD on an identified date indicated that they received referrals in Point Click Care (PCC) for residents with a change in their weight of two kg or more. They identified that they had received a list of residents that were waiting to be re-weighed from the Nutrition Manager and confirmed that they had not yet received a referral for resident #002's unintentional weight loss.

Interview with the ADOC and DOC acknowledged that there was no documentation that a re-weigh for the resident had occurred. They confirmed that resident #002 was not assessed by the RD when they experienced a weight loss of 5.6 % in an identified month and year and that the home had not complied with their policy.

B) Resident #003's clinical record identified that they were on a specified diet and texture and were identified as having a specified nutrition risk. The resident's weights on

two specified dates, one month apart were identified to represent a weight loss of 5.3 kg and 12.9 % over one month.

Interview with the RD on an identified date indicated that they received referrals in PCC for residents with a change in their weight of two kg or more. They identified that they had received a list of residents that were waiting to be re-weighed from the Nutrition Manager and confirmed that they had not yet received a referral for resident #003's unintentional weight loss.

Interview with the ADOC and DOC acknowledged that there was no documentation that a re-weigh for the resident had occurred. They confirmed that resident #003 was not assessed by the RD when they experienced a weight loss of 12.9 % in an identified month and year and that the home had not complied with their policy.

C) Resident #005's clinical record identified that they were on a specified diet and texture and were identified as having a specified nutrition risk. The resident's weights on two specified dates, one month apart were identified to represent a weight loss of 10.5 kg and 11.9 % over one month.

Interview with the RD on an identified date indicated that they received referrals in PCC for residents with a change in their weight of two kg or more. They identified that they had received a list of residents that were waiting to be re-weighed from the Nutrition Manager. The RD identified that they had not yet received a referral for resident #005's weight loss and that they would have expected to receive a referral for the resident's weight loss.

Interview with the ADOC and DOC acknowledged that there was no documentation that a re-weigh for the resident had occurred. They confirmed that resident #003 was not assessed by the RD when they experienced a weight loss of 12.9 % in an identified month and year and that the home had not complied with their policy. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee did not ensure that any plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with applicable requirements under the Act in relation to O. Reg. 79/10, s. 50. (2) (b) (iii) which requires every licensee of a long-term care home to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a registered dietician who is a member of the staff of the home, and any changes made

to the resident's plan of care relating to nutrition and hydration are implemented.

A review of the home's policy titled, "Skin and Wound Care-Program" (Nursing Manual and dated with a revision date of March 2016) indicated that the Dietician will be notified by unit's Registered Staff and will complete the dietary referral/consult for all skin tears and stage 2 or higher pressure ulcers and full thickness wounds. The Dietician will assess the resident for interventions in relation to nutrition and hydration.

An interview with the DOC confirmed that the home's policies were not in compliance with the applicable requirements under the Act in relation to skin and wound. [s. 8. (1) (a),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 and to ensure that that any plan, policy, protocol, procedure, strategy or system is in compliance with and is implemented in accordance with applicable requirements under the Act in relation to O. Reg. 79/10, s. 50. (2) (b) (iii) which requires every licensee of a long-term care home to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a registered dietician who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff if clinically indicated.

A) Resident #015 was admitted to the home on an identified date, with an identified alteration to their skin integrity to a specified area. At the time of admission until approximately three months later, the resident was receiving an identified therapy. At the time of this inspection the identified alteration to the resident's skin integrity was identified to be improving. A review was completed of the weekly wound assessments for an identified period of three months. The review identified that a wound assessment had not been completed on five specified dates during the review period. Registered staff #112 who oversees the skin and wound care program in the home confirmed that weekly wound assessments had not been completed on the dates identified.

B) Review of resident #006's quarterly Minimum Data Set (MDS) coding and a corresponding identified Resident Assessment Protocol (RAP) dated on an identified date, indicated that the resident was coded as having an identified alteration to their skin integrity to a specified area. A review of the resident's next quarterly MDS coding and corresponding identified narrative RAP indicated that the resident was coded as having a decline to the identified alteration to their skin integrity.

An interview with registered staff #112, who is the home's wound care nurse on an identified date, indicated that the resident did not have the identified level of alteration to their skin integrity to the specified area; however, they had another specified alteration to their skin integrity to identified areas.

An observation of the resident's altered skin integrity by registered staff #112 and the Inspector on an identified date, confirmed that the resident did not have the initially specified level of alteration to their skin to a specified area and was demonstrating a different level of alteration to their skin to specified areas.

A review of resident #006's weekly wound reassessments in PCC for an identified period of approximately two and a half months, indicated that weekly wound reassessments had not been completed on four identified dates during the time period reviewed.

An interview with the DOC and registered staff #112 confirmed that resident #006's altered skin integrity had not been reassessed at least weekly. (Inspector #214) [s. 50. (2) (b) (iv)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff if clinically indicated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

An observation of the four locked, medication storage areas in the home on a specified date, identified cabinets which were used to store discontinued controlled substances and narcotics, were stored in the locked medication rooms. Observation of the cabinets on identified units with the ADOC identified that the cabinets had not been locked and the cabinet doors were able to be opened, revealing discontinued controlled substances and narcotics.

Observation of the cabinets located in all four medication storage areas indicated that only one locking mechanism was present. All four cabinets were observed to be sitting on top of a small refrigerator in each locked medication storage area and the DOC who was present was able to lift the cabinet up from the surface of the refrigerator.

An interview with the DOC and the ADOC confirmed that the cabinets used to store discontinued controlled substances and narcotics in all four locked medication storage areas, had not been double-locked and were not stationary.

On an identified date, the pharmacy liaison staff member and the DOC confirmed that an audit of all four medication storage areas had been conducted and all discontinued controlled substances and narcotics had been accounted for in all four medication storage areas.

On a later identified date, all four cabinets used to store discontinued controlled substances and narcotics were observed to be secured to the wall in the locked area and observed to have a double-locking mechanism on each cabinet. [s. 129. (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 controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A) A review of a medication incident report on an identified date, indicated that resident # 011 had not received their weekly identified medication card from the pharmacy. The form contained an area to check that the incident was reported to the DOC and an area for the DOC to sign and date. Both of these areas on the form were blank.

B) A review of a medication incident report dated on an identified date, indicated that a new identified prescription for resident #012 had been received from the emergency pharmacy the day prior; however, the prescription for the remainder of the week had not been sent on the following evening. The form contained an area to check that the incident was reported to the DOC and an area for the DOC to sign and date. Both of these areas on the form were blank.

An interview with the DOC confirmed that the above medication incidents had not been reported to the DOC. [s. 135. (1)]

2. The licensee failed to ensure that, (a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions and any changes and improvements identified in the review were implemented and a written record was kept of everything provided for in clauses (a) and (b).

An interview with the DOC on an identified date, confirmed that the home had not undertaken a quarterly review of all medication incidents and adverse drug reactions since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions. [s. 135. (3)]

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 every medication incident involving a resident and every adverse drug reaction is (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider and to ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions and any changes and improvements identified in the review are implemented and a written record is kept of everything provided for in clauses (a) and (b), to be implemented voluntarily.

WN #5: 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. (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 staff participated in the implementation of the infection prevention and control program.

A) On an identified date, during a tour of the home, the inspector observed the following used, unlabeled personal items:
- One comb in the spa room on an identified unit.
- Two hairbrushes in the spa room and one comb in the shower room on an identified unit.
- One comb, one hairbrush, one roll on deodorant and a pair of nail clippers in the spa room and one roll on deodorant in the shower room on an identified unit. PSW #102 confirmed that the personal hygiene items should have been labelled.

Interview with the DOC identified that it was the home's expectation that personal care items, including combs, brushes, deodorant and nail clippers were labelled and were for individual resident use only.

B) During a tour of identified spa and shower rooms on a specified date, two jars of Vitarub and two jars of Petroleum Jelly were observed to have been opened, used and not labelled.

An interview with the DOC confirmed that these items were to be labelled and for individual resident use only.

The licensee did not ensure that staff participated in the implementation of the infection prevention and control program. [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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the nutrition care and hydration program included a weight monitoring system to measure and record with respect to each resident height on admission and annually thereafter.

A) Review of the clinical record for resident #001 identified the resident's most recent height to have been documented 14 months prior. There were no other documented heights for the resident, nor was documentation found of the resident refusing height measurement.

B) Review of the clinical record for resident #010 identified the resident's most recent height to have been documented 14 months prior. There were no other documented heights for the resident, nor was documentation found of the resident refusing height measurement.

C) Review of the clinical record for resident #004 identified the resident's most recent height to have been document approximately two years prior. There were no other documented heights for the resident, nor was documentation found of the resident refusing height measurement.

D) Review of the clinical record for resident #008 identified the resident's most recent height to have been documented approximately 15 months prior. There were no other documented heights for the resident, nor was documentation found of the resident refusing height measurement.

E) Review of the clinical record for resident #009 identified the resident's most recent height to have been documented approximately two years prior. There were no other documented heights for the resident, nor was documentation found of the resident refusing height measurement.

Interview with the ADOC confirmed that the only place the heights were documented was in PCC and confirmed that the above residents heights had not been measured annually. [s. 68. (2) (e) (ii)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to the residents received as a condition to continuing to have contact with residents annual retraining in accordance to O. Reg. 79/10, s. 219. (1) in the area of skin and wound care management in accordance with O. Reg. 79/10, s. 221. (1) 2, in relation to the following: s. 76. (7) 6.

An interview with the DOC on an identified date indicated that skin and wound training records for all direct care staff for an identified year, were unable to be located at the time of this inspection and were unsure how many direct care staff had received training. [s. 76. (7) 6.]

Issued on this 18th day of December, 2017

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

Original report signed by the inspector.