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 prévue 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 6, 2019	2019_577611_0011	025661-18, 002923-19	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): February 26, 27, and 28, 2019.

Please note: This CIS inspection was conducted concurrently with a follow up inspection Log #000069-19.

During the course of the inspection, the inspector(s) observed the provision of resident care, staff to resident interactions, reviewed resident clinical health records; relevant policies and procedures; the home's internal investigative notes, staff training records, program evaluations, and medication incident reports.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), registered staff, Personal Support Workers (PSWs), and residents.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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	Légende 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. 6. Plan of care

Specifically failed to comply with the following:

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/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

In September 2018, the licensee submitted a CIS report #C571-000009-18, which indicated that the home was investigating allegations of abuse towards resident #002. A review of the homes investigation notes indicated that staff #101 was providing personal care to resident #002 in September 2018. During this care, resident #002 was exhibiting responsive behaviours related to the care that was being provided. According to the homes investigation notes, staff #101 continued to provide the care to resident #002. In response to this, resident #002 exhibited responsive behaviours towards staff #101.

Staff #101 left the room, and asked for staff #104 and staff #109 to continue with the care for resident #002. Upon entering the room, resident #002 was visibly upset, and had sustained an injury.

In an interview conducted with staff #104 in February 2019, it was confirmed that upon entering resident #002's room at the request of staff #101, resident #002 had an injury. Staff #104 identified that this injury was not present when they assisted with care during the same shift. It was further confirmed that resident #002 was demonstrating responsive behaviours, and staff #104 confirmed this behaviour was not normal for resident #002.

In an interview conducted with staff #103 in February 2019, it was confirmed that after the incident in September 2018, staff #103 observed resident #002 and had observed the injury, and further confirmed that this injury was not there earlier during the same shift.

In a physician progress note from September 2018, it outlined an assessment of resident #002's unexplained injuries.

Resident #002's written plan of care from August 2018, indicated that this resident demonstrated responsive behaviours when care was provided related to cognitive impairment. The interventions for this responsive behaviour as identified in the plan of care were to allow for the flexibility in the Activities of Daily Living (ADL) routine to accommodate the residents responsive behaviours.

According to the homes investigation notes, staff #101 did not follow resident #002's written plan of care until after this resident sustained injuries as a result of continuing the care. Specifically staff #101 did not allow for the flexibility in their ADL routine to accommodate the resident's responsive behaviours.

In an interview conducted with the Director of Care in February 2018, it was confirmed that staff #101 did not provide care to resident #002 as specified in the plan of care at the time of the above noted incident. [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 failed to ensure that all residents were protected from abuse by anyone.

O.Reg. 79/10, s. 2 (1) definition includes physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain, administering or withholding a drug for an inappropriate purpose, or the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitement d'ordre physique")

In September 2018, the licensee submitted a CIS report #C571-000009-18, which indicated that the home was investigating allegations of abuse towards resident #002. A review of the homes investigation notes indicated that staff #101 was providing personal care to resident #002 in September 2018. During this care, resident #002 was exhibiting responsive behaviour. According to the homes investigation notes, staff #101 continued to provide the care to resident #002. In response to this, resident #002 exhibited responsive behaviours towards staff #101.

Staff #101 left the room, and asked for staff #104 and staff #109 to continue with the care. Upon entering the room, resident #002 was visibly upset, and had an injury.

In an interview conducted with staff #104 in February 2019, it was confirmed that upon entering resident #002's room at the request of staff #101, resident #002 had an injury, and this injury was not present when they assisted with care during the same shift. It was further confirmed that resident #002 was demonstrating responsive behaviours .

In an interview conducted with staff #103 in February 2019, it was confirmed that after the incident in September 2018, staff #103 observed resident #002 and observed the injury, and further confirmed that this injury was not there earlier during the same shift.

In a physician progress note from September 2018, it outlined an assessment of resident #002's unexplained injuries.

The home's investigation concluded that staff #101's actions constituted abuse, and that their actions caused the injury to resident #002. Staff #101 was issued a letter of discipline in September 2018.

In an interview conducted with the Director of Care in February 2018, it was confirmed that the interaction that took place between staff #101 and resident #002 was a form of abuse towards resident #002. [s. 19. (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 all residents are protected from abuse by anyone, to be implemented voluntarily.

Issued on this 13th day of March, 2019

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

Original report signed by the inspector.