



**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
prévus le Loi de 2007 les
foyers de soins de longue**

Health System Accountability and Performance
Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jul 27, 28, Aug 2, 3, 2011	2011_060127_0020	Critical Incident

Licensee/Titulaire de permis

MENNONITE BROTHERS SENIOR CITIZENS HOME
1 Tabor Drive, St. Catharines, ON, L2N-1V9

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

MENNONITE BROTHERS SENIOR CITIZENS HOME
1 Tabor Drive, St Catharines, ON, L2N-1V9

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

RICHARD HAYDEN (127)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with a resident, the executive director, director, environmental services supervisor, registered and non-registered staff.

During the course of the inspection, the inspector(s) reviewed a resident's file and management's documentation of the incident, observed residents and checked the security of doors.

The following Inspection Protocols were used in part or in whole during this inspection:

Critical Incident Response

Personal Support Services

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 subsections:

- 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;**
 - (b) the resident's care needs change or care set out in the plan is no longer necessary; or**
 - (c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

Findings/Faits sayants :

1. An identified resident was assessed by the care team as no longer requiring the use of a personal assistive device. The physician ordered use of the device be ceased.
2. The resident's plan of care was not updated to reflect the physician's order.

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 with ensuring the plan of care is reviewed and revised at any time the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

- s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**
- 1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.**
 - 2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.**
 - 3. A missing or unaccounted for controlled substance.**
 - 4. An injury in respect of which a person is taken to hospital.**
 - 5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).**

Findings/Faits sayants :



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1. The inspector confirmed that an identified resident was absent from Tabor Manor for approximately one and a half hours without staff knowledge of his/her whereabouts.
2. The Critical Incident Report related to this incident was not reported to the Ministry of Health and Long-Term Care until five days after the incident.

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 with ensuring that the Director is informed no later than one business day following an incident where a resident is missing less than three hours and who returns to the home with no injury or adverse change in condition, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home must be,
 - i. kept closed and locked,
 - ii. equipped with a door access control system that is kept on at all times, and
 - iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
 - A. is connected to the resident-staff communication and response system, or
 - B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents.
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans. O. Reg. 79/10, s. 9.

Findings/Faits sayants :

1. On July 29, 2011 the inspector observed that the main floor door leading to the stairway to the basement did not have a door access control system that is on at all times and was not equipped with an audible door alarm that allows calls to be cancelled only at the point of activation.

Issued on this 3rd day of August, 2011

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