Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Sep 16, 2021	2021_905683_0014	008283-20, 008354-21, 011769-21, 012767-21	Critical Incident System

Licensee/Titulaire de permis

Mennonite Brethren Senior Citizens Home
1 Tabor Drive St Catherines ON L2N 1V9

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

Mennonite Brethren Senior Citizens Home
1 Tabor Drive St Catherines ON L2N 1V9

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

LISA BOS (683)

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): August 31, September 1, 2, 3, 8, 9, 10 and 13, 2021.

This inspection was completed concurrently with complaint inspection #2021_905683_0013.

The following intakes were completed during this critical incident inspection: Log #008283-20, #008354-21, #011769-21 and #012767-21 were related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Acting Director of Care (DOC), Physician, Assistant Resident Assessment Instrument (RAI) Coordinator, Maintenance, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and families.

During the course of the inspection, the Inspector(s) toured the home, observed the provision of care, infection prevention and control practices and reviewed clinical health records, relevant home policies and procedures, temperature logs and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that different approaches were considered when a resident was reassessed and the plan of care reviewed, when the care set out in the plan had not been effective.

A resident's clinical record indicated that they were at a risk of falls and required an intervention to try and prevent falls. Two different RPNs documented that the intervention was ineffective and suggested a different intervention they felt the resident required. Two days later, the resident sustained a fall and in the post fall assessment, the RPN documented that their care plan was reviewed, and no update was required. The next day, the resident sustained a fall which resulted in an injury.

The Acting Director of Care (DOC) acknowledged that as per the available documentation, the staff were aware the intervention was ineffective and they did not do anything about it.

Two RPNs documented that the intervention was ineffective and after the resident sustained another fall and was reassessed by a RPN, there were no revisions made to the resident's plan of care to prevent further falls. By failing to revise the resident's plan of care when the intervention was ineffective, the resident was at risk of harm from a fall, and the next day, the resident sustained another fall which resulted in an injury.

Sources: A resident's clinical record; interview with the Acting DOC and other staff [s. 6. (11) (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 when a resident is reassessed and the plan of care reviewed and revised, if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature was measured and documented in writing at a minimum in at least two resident bedrooms in different parts of the home and one resident common area on every floor of the home, and that the temperature was documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

A review of the "Tabor Manor Daily Room Temperature and Humidity Record Chart" indicated that temperatures were being monitored daily at 1000 and 1400 hours in a single resident room.

A maintenance staff member confirmed that the temperatures were only measured in one resident room at 1000 and 1400 hours and that temperatures were not measured in one resident common area on each floor of the home.

Sources: Tabor Manor Daily Room Temperature and Humidity Record Chart; interview with a maintenance staff member [s. 21. (2) 1.]

WN #3: 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 has failed to ensure that a post fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls after a resident sustained a fall.

A resident was at a risk of falls and required the assistance of staff for ambulation. They fell when ambulating with staff and sustained an injury.

The home's "Falls Prevention and Management Program" policy and procedure, dated June 2016, defined a fall as "any unintentional change in position where the resident ends up on the floor, ground or other lower level" and a near fall/near miss as "a sudden loss of balance that does not result in a fall or other injury. This can include a person who slips, stumbles or trips but is able to regain control prior to falling."

A RPN reported that when a resident sustained a fall, a post fall assessment was to be completed in the assessments tab in Point Click Care (PCC).

A RPN documented the resident's fall as a near miss and a review of the resident's clinical record did not identify a post fall assessment using a clinically appropriate assessment instrument.

The Acting DOC acknowledged that the resident sustained a fall, not a near miss, as it resulted on them on the floor. Along with the Assistant Resident Assessment Instrument (RAI) Coordinator, they confirmed that a post fall assessment was not completed using a clinically appropriate assessment instrument that was specifically designed for falls when the resident fell.

Sources: A resident’s clinical record; Falls Prevention and Management Program policy dated June 2016; interviews with a RPN, the Acting DOC, Assistant RAI Coordinator and other staff. [s. 49. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

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):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident which caused an injury to residents for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition no later than one business day after the occurrence of the incident.

In accordance with O. Reg. 79/10, s. 107(7) "significant change" is defined as a major change in the resident's health condition that,
(a) will not resolve itself without further intervention,
(b) impacts on more than one aspect of the resident's health condition, and
(c) requires an assessment by the interdisciplinary team or a revision to the resident's plan of care.

A) A resident sustained a fall and upon initial assessment there was no evidence of significant injuries. After continued reports of pain, a follow up diagnostic service was ordered, an injury was diagnosed, and the resident was transferred to hospital for medical intervention.

The home did not submit a Critical Incident (CI) report to the Director until five days after the resident received a diagnosis and was sent to hospital.

In an interview with the Acting DOC, they reported that they initiated the CI report on the date the resident was transferred to hospital, but did not submit it to the Director until five days later. They acknowledged that the resident experienced a significant change in their health condition and that the Director was not informed of the incident within one business day after it occurred.

Sources: A CI report; a resident's clinical record; interview with the Acting DOC and other

staff.

B) A resident sustained a fall which resulted in an injury and transfer to hospital.

The home did not submit a CI report to the Director until 15 days after their significant change in status and transfer to hospital.

In an interview with the Acting DOC, they acknowledged that the resident was sent to hospital and experienced a significant change in their health condition and that the Director was not informed of the incident within one business day after it occurred.

Sources: A CI report; a resident's clinical record; interview with the Acting DOC and other staff. [s. 107. (3) 4.]

Issued on this 16th day of September, 2021

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

Original report signed by the inspector.