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_0013	000938-21	Complaint

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 Complaint 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 critical incident inspection #2021_905683_0014.

The following intake was completed during this complaint inspection:
Log #000938-21 was related to the Resident's Bill of Rights.

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 and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

During the course of this inspection, Non-Compliances were issued.
- **1 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's right to have family present 24 hours per day was fully respected and promoted when they were very ill.

A complaint was submitted to the Director regarding family being denied entry to the long-term care home to visit a resident when they were very ill.

A resident's clinical record indicated that they began to feel unwell and were diagnosed with an acute illness. Over the next few days their condition deteriorated and required medical treatment. The resident's family contacted the Acting Director of Care (DOC) regarding their ability to visit the resident. They attempted to visit the resident but were not allowed entry into the home.

The Acting Director of Care (DOC) acknowledged that the resident was very ill and that the resident's family should not have been denied entry to the home.

A resident who had an acute illness that required medical treatment was not afforded the right to have family present 24 hours a day when their family was denied access to the home.

Sources: A resident's clinical record; interview with a Physician, the Acting DOC and other staff. [s. 3. (1) 15.]

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 resident who is very ill has the right to have family and friends present 24 hours per day, to be implemented voluntarily.

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.