Ontario

**Inspection Report Under the**
**Fixing Long-Term Care Act, 2021**

**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**Hamilton District**
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

# Original Public Report

**Report Issue Date:** March 7, 2024

**Inspection Number:** 2024-1511-0001

**Inspection Type:**
Proactive Compliance Inspection

**Licensee:** Mennonite Brethren Senior Citizens Home

**Long Term Care Home and City:** Mennonite Brethren Senior Citizens Home, St Catherines

| **Lead Inspector** | **Inspector Digital Signature** |
|---|---|
| Sydney Withers (740735) | Sydney Withers Digitally signed by Sydney Withers Date: 2024.03.12 11:55:17 -04'00' |

**Additional Inspector**
Jennifer Allen (706480)

# INSPECTION SUMMARY

The inspection occurred on-site on the following dates: February 7-9, 12-13, 15-16, 20-23, 2024.

The following intake was inspected:

- Intake 00108330: Proactive Compliance Inspection (PCI) for Mennonite Brethren Senior Citizens Home

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The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 6 (1) (c)**

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that the written plan of care for a resident set out clear directions for staff and others who provided direct care to the resident.

**Rationale and Summary**

During a meal service observation, a resident received a nutrition intervention that was not reflective of their most recent nutrition assessment. The Dietary Aide (DA) indicated that the meal service report listed the intervention as acceptable for the resident. They confirmed that the meal service report did not set out clear directions for dietary staff related to the resident's needs at meal service. The Registered Dietitian (RD) confirmed that the resident was to receive the intervention specified in their most recent nutrition assessment.

Failure to ensure the written plan of care set out clear directions related to the resident's nutrition needs may have impacted their intake and safety at mealtime.

**Sources:** Meal observation, resident's clinical record, meal service report, interviews with the DA and RD. [740735]

## WRITTEN NOTIFICATION: Integration of Assessments, Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 6 (4) (a)**

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee failed to ensure that staff involved in the different aspects of a resident's care collaborated with each other in the assessment of the resident so that their assessments were integrated and consistent with each other.

**Rationale and Summary**

A resident's admission skin assessment indicated they had a wound. The initial physiotherapy assessment conducted by the Physiotherapist (PT) did not include the resident's wound and resulted in the resident's enrollment into a specified PT program, to be delivered by a physiotherapy assistant (PTA).

The PT acknowledged that they were not aware of the resident's wound at the time of their initial assessment. They indicated that the location of the resident's wound may contraindicate their participation in the PT program. The PTA acknowledged that when they approached the resident regarding participation in the PT program, the resident refused participation due to pain at the site of their wound.

When registered nursing staff and the PT failed to ensure their assessments were integrated and consistent with each other, the resident may not have received care or services clinically indicated by their altered skin integrity.

**Sources:** Resident's clinical record, interviews with the PT and PTA. [740735]

## WRITTEN NOTIFICATION: Duty of Licensee to Comply with Plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 6 (7)**

Plan of care

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.

The licensee failed to ensure that a resident's food preferences were followed as specified in their plan of care.

**Rationale and Summary**
During a meal observation, a resident received a food specified as a dislike in their plan of care. The DA acknowledged that the resident did not like the item they had been served and that they were served it in error.

**Sources:** Meal observation, resident's clinical record, meal service report, interviews with the DA and a personal support worker (PSW). [740735]

## WRITTEN NOTIFICATION: Policy to Minimize Restraining of Residents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 33 (1) (b)**
Policy to minimize restraining of residents, etc.
s. 33 (1) Every licensee of a long-term care home,
(b) shall ensure that the policy is complied with.

The licensee failed to comply with the home's restraint policy for a resident. Specifically, written consent and monitoring was not put in place according to their policy.

**Rationale and Summary**
A resident's health record indicated that they used a mobility aid. A physician's order documented that a restraint was to be in use when the resident was using their mobility aid, to support with positioning. Resident observations confirmed that the restraint was in place at the time of inspection.

The home's restraint policy stated signed consent must be received from the resident and/or their substitute decision maker (SDM) and that staff shall document every two hours when the resident is released, repositioned, and when the care plan

interventions have been followed.

A. Documentation for a specified period demonstrated inconsistent documentation when the restraint was applied and released.

B. Documentation on a specified date, showed that the resident's SDM verbally agreed with the use of the restraint; however, there was no evidence that the SDM had completed and signed the assessment form providing written consent for the restraint as required by the home's policy.

Failing to comply with the home's restraint policy regarding implementing and monitoring the safe use of a restraint posed a risk of serious bodily harm.

**Sources**: Restraint - Personal Assistance Service Devices, and Restraints Policy (Last revised January 2024), Radiant Care Tabor Manor Documentation Survey Report, Point of Care, resident's health records, Interview with a registered practical nurse (RPN) and the Clinical Resource Lead. [706480]

## WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey - Documentation

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 43 (5) (b)**
Resident and Family/Caregiver Experience Survey
s. 43 (5) The licensee shall ensure that,
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any;

The licensee failed to ensure any actions taken to improve the long-term care home

(LTCH), and the care, services, programs and goods based on the results of the survey were documented.

**Rationale and Summary**
Documentation of the 2022 survey results indicated numerous comments with feedback related to the LTCH's care, services, programs and goods, including, but not limited to, dining, chapel, and personal care and support services, including continence care. The Administrator acknowledged that the home did not maintain documentation of actions taken to improve the LTCH based on the 2022 survey results.

**Sources:** 2022 Resident and Family/Caregiver Experience Survey, interview with the Administrator. [740735]

## WRITTEN NOTIFICATION: Licensee Obligations if No Family Council

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 65 (7) (b)**
Family Council
s. 65 (7) If there is no Family Council, the licensee shall,
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council.

When there was no Family Council, the licensee failed to ensure semi-annual meetings were convened to advise residents' families and persons of importance to residents of their right to establish a Family Council.

**Rationale and Summary**
The Therapeutic Recreation Supervisor and Administrator acknowledged that semi-

annual meetings have not been convened to advise the required individuals of their right to establish a Family Council.

Failure to convene semi-annual meetings regarding the right to establish a Family Council may have led to gaps in stakeholder awareness about their right to and the functions of Family Council in long-term care.

**Sources:** Interviews with the Therapeutic Recreation Supervisor and Administrator. [740735]

## WRITTEN NOTIFICATION: Skin and Wound Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)**
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee failed to ensure a resident's altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

**Rationale and Summary**
A resident's admission skin assessment indicated they had a wound. A gap in weekly wound reassessments was identified. The size of the resident's wound increased during the time the assessments were missed. A registered nurse (RN) acknowledged the gap in weekly wound reassessments and indicated that the need for a weekly wound reassessment was not entered into the electronic medical

record; therefore, registered nursing staff would not have been prompted to complete an assessment.

Failure to ensure the resident's altered skin integrity was reassessed at least weekly increased the risk of changes in their wound not being identified.

**Sources:** Resident's clinical record, interview with an RN. [740735]

## WRITTEN NOTIFICATION: Menu Planning

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 77 (5)**
Menu planning
s. 77 (5) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 246/22, s. 390 (1).

The licensee failed to ensure that a planned menu item was offered at an observed meal service.

**Rationale and Summary**
The posted seven-day and daily menus indicated that a specified food item was a planned menu item for meal service on a specified day. During a meal observation, the food item was not offered to residents during meal service. The DA acknowledged that the food item was available at the servery; however, it was not offered to residents at the time of the meal service.

**Sources:** Meal observation, seven-day menu, interviews with a resident and the DA. [740735]

## WRITTEN NOTIFICATION: Medication Management Policies

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)**

Medication management system

s. 123 (3) The written policies and protocols must be,

(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee failed to ensure that the Medication Management System's written policies and protocols were implemented in accordance with evidence-based practices or accordance with prevailing practices. Specially, the Medication – Security and Accountability policy,

**Rationale and Summary**

An RPN was observed completing a medication pass for a resident. When the RPN was preparing the medication for administration against the electronic Medication Administration Record (eMAR), they signed the eMAR before administering the medication to the resident. The RPN acknowledged they should have signed the eMAR after medication administration.

The Medication – Security and Accountability Policy stated registered nursing staff must sign the eMAR immediately after the administration of a resident's individual medications.

**Sources**: Medication pass observation, The Medication – Security and Accountability Policy, dated 2013; interviews with an RPN and Pharmaceutical Consultant. [706480]

## WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 138 (1) (b)**

Safe storage of drugs

s. 138 (1) Every licensee of a long-term care home shall ensure that,

(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.

The licensee failed to ensure that the narcotic cabinet was double-locked in a separate locked area within the locked medication cart.

**Rationale and Summary**

During a medication observation, the narcotic cabinet in the bottom drawer of the medication cart was not locked or secured. When the RPN opened the bottom drawer of the medication cart to retrieve a narcotic medication from the narcotic cabinet, the narcotic cabinet was observed to be open.

The homes' policy Medication - Controlled Medications required narcotics and controlled medications to be stored in a locked box, in a locked medication cart in a securely locked room when not in use. The RPN stated they were aware of the requirements to keep the narcotic cabinet in the medication cart locked when not in use.

Failure to double-lock the narcotic medications in a separate area within the locked medication cart increased the risk of narcotic and controlled medication theft.

**Sources**: Medication pass observation, Medication - Controlled Medications Policy (last revised; January 2020); interview with an RPN and Pharmaceutical Consultant. [706480]

## WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. iii.**
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee failed to ensure that the report required under subsection 168 (1) included a written record of how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to members of the staff of the home.

**Rationale and Summary**
The home's continuous quality improvement (CQI) report for the fiscal year ending March 31, 2023 did not include a written record of how, and the dates when, the results of the survey taken in 2022 were communicated to the required stakeholders.

**Sources:** 2023 CQI Report, interview with the Administrator. [740735]

## WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. i.**

Continuous quality improvement initiative report

s. 168 (2) The report required under subsection (1) must contain the following information:

6. A written record of,

i. the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,

The licensee failed to ensure that the report required under subsection 168 (1) included a written record of the actions taken to improve the LTCH, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions.

**Rationale and Summary**

The home's CQI report for the fiscal year ending March 31, 2023 did not include a written record of actions taken to improve the LTCH based on the results of the survey taken in 2022, the required dates or outcomes of the actions.

**Sources:** 2023 CQI report, interview with the Administrator. [740735]

## WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. ii.**

Continuous quality improvement initiative report

s. 168 (2) The report required under subsection (1) must contain the following information:

6. A written record of,

ii. any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions,

The licensee failed to ensure that the report required under subsection 168 (1) included a written record of any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions.

**Rationale and Summary**

The home's CQI report for the fiscal year ending March 31, 2023 did not include a written record of any other actions taken to improve the LTCH in the home's priority areas for quality improvement during the 2022/2023 fiscal year, the required dates or outcomes of the actions.

**Sources:** 2023 CQI report, interview with the Administrator. [740735]

## WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. iii.**
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
iii. the role of the Residents' Council and Family Council, if any, in actions taken under subparagraphs i and ii,

The licensee failed to ensure that the report required under subsection 168 (1) included a written record of the role of the Residents' Council and Family Council in actions taken under subparagraphs i and ii.

**Rationale and Summary**
The home's CQI report for the fiscal year ending March 31, 2023 did not describe the role of either council in actions taken under subparagraphs 168 (2) 6. i and ii.

**Sources:** 2023 CQI report, interview with the Administrator. [740735]

## WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. iv.**
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:

6. A written record of,
iv. the role of the continuous quality improvement committee in actions taken under subparagraphs i and ii, and

The licensee failed to ensure that the report required under subsection 168 (1) included a written record of the role of the CQI committee in actions taken under subparagraphs i and ii.

**Rationale and Summary**
The home's CQI report for the fiscal year ending March 31, 2023 did not include a written record of the role of the CQI committee in actions taken under subparagraphs 168 (2) 6. i and ii.

**Sources:** 2023 CQI report, interview with the Administrator. [740735]

## WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. v.**
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.
The licensee failed to ensure that the report required under subsection 168 (1) included a written record of how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the

Residents' Council, Family Council and members of the staff of the home.

**Rationale and Summary**
The home's CQI report for the fiscal year ending March 31, 2023 did not include a written record of how, and the dates when, the actions taken under subparagraphs 168 (2) 6. i and ii were communicated to the required stakeholders.

**Sources:** 2023 CQI report, interview with the Administrator. [740735]

## WRITTEN NOTIFICATION: Additional Training — Direct Care Staff

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 261 (1) 2.**
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care.

The licensee failed to ensure all staff who provided direct care to residents received training related to skin and wound care.

**Rationale and Summary**
Training related to skin and wound care was to be provided to all direct care staff annually, according to paragraph 1 of Ontario Regulation 246/22 subsection 261 (2). The Administrator acknowledged that the skin and wound care program and training content were not uploaded to the LTCH's online training platform in 2023, resulting in a training gap for all direct care staff.

Failure for the home to provide annual training to the required individuals increased

the risk of staff not understanding their responsibilities as set out in the home's skin and wound care program.

**Sources:** Interview with the Administrator. [740735]

## WRITTEN NOTIFICATION: Additional Training — Direct Care Staff

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 261 (1) 4.**
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain.

The licensee failed to ensure all staff who provided direct care to residents received training related to pain management.

**Rationale and Summary**
Training related to pain management was to be provided to all direct care staff annually, according to paragraph 1 of Ontario Regulation 246/22 subsection 261 (2). The Administrator acknowledged that the pain management program and training content were not uploaded to the LTCH's online training platform in 2023, resulting in a training gap for all direct care staff.

Failure for the home to provide annual training to the required individuals increased the risk of staff not understanding their responsibilities as set out in the home's pain management program.

**Sources:** Interview with the Administrator. [740735]

## WRITTEN NOTIFICATION: Posting of Information

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.**
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure that the current version of the visitor policy was posted in the home and communicated to residents under section 5 of the Act as required.

**Rationale and Summary**
During a tour of the home, the current version of the visitor policy was not posted in the home. The Senior Administrator confirmed that the policy was not posted.

**Sources**: LTCH observations, interview with the Senior Administrator. [706480]