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
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Original Public Report

Report Issue Date: December 3, 2024

Inspection Number: 2024-1511-0003

Inspection Type:
Complaint
Critical Incident

Licensee: Mennonite Brethren Senior Citizens Home

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 7-8, 12-14, 18-21, 2024.

The following intakes were inspected:

- Intake: #00124814, Critical Incident (CI) 3016-000015-24 was related to parainfluenza virus outbreak,
- Intake: #00125136, CI 3016-000016-24 was related to improper/incompetent treatment or care,
- Intake: #00128621, CI 3016-000020-24 was related to rhinovirus outbreak,
- Intake: #00129137, CI 3016-000022-24 was related to falls prevention and management,
- Intake: #00129138, complaint was related to plan of care, skin and wound care, and falls prevention and management; and,
- Intake: #00131956, CI 3016-000025-24 was related to COVID-19 outbreak.

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

Falls Prevention and Management
Infection Prevention and Control
Pain Management
Reporting and Complaints
Skin and Wound 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 (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 has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary
A resident's care plan specified that staff were to apply a specific fall prevention intervention. The intervention was initiated at the request and approval of the resident's substitute decision maker (SDM).

A personal support worker (PSW) assisted the resident with their evening care, but neglected to apply the fall prevention intervention. Because the fall prevention intervention was not in place the resident fell forward on to the floor when they exited the washroom. The resident sustained two areas of altered skin integrity.

A registered nurse (RN) assessed the resident and determined that due to the nature of one of the areas of altered skin integrity, the resident needed to go to the hospital. The RN stated that the PSW told her that the fall prevention intervention was not in place when the resident exited the washroom.

The Director of Care (DOC) acknowledged that the PSW did not apply the resident's fall prevention interventions as per their plan of care which resulted in a significant injury to the resident.

Failure to provide care as per the plan of care led to the resident's fall, resulting in two areas of altered skin integrity.

Sources: resident's clinical records, home's investigation notes including interviews; and interviews with staff.

WRITTEN NOTIFICATION: Reporting and Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a person who has reasonable grounds to suspect that improper or incompetent care of a resident that resulted in harm occurred immediately report the suspicion and the information upon which it is

based to the Director.

Rationale and Summary
A resident had a fall that resulted in two areas of altered skin integrity. An RN explained that a PSW said that they did not apply the resident's fall prevention intervention after provided evening care. As a result, when the resident exited the washroom, they fell on the floor.

The RN stated and documented that they contacted the DOC that evening to inform them that the resident was transferred to the hospital. The DOC acknowledged that the Ministry of Long-Term Care's after-hours line should have been used to report the incident when they were informed by the RN.

Failure to immediately notify the Director of improper or incompetent care of a resident that resulted in harm had the potential for the Director to be unaware of the incident and to take actions as needed.

Sources: resident's clinical records, risk management documentation; and interviews with the DOC and other staff.

WRITTEN NOTIFICATION: Minimizing of Restraining

NC #003 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 has failed to ensure that their policy to minimize the restraining of residents was complied with.

Rationale and Summary
A resident's SDM requested and consented for the use of a physical restraint to be used as a fall prevention intervention over two years earlier. Since that time, the resident's plan of care specified when the restraint was to be applied.

The home's policy, Personal Assistive Services Device (PASD) and Restraints, stated that the need for a restraint shall be reevaluated each quarter.

The DOC explained that restraints, even if requested by a resident's SDM, should be evaluated quarterly to ensure a resident was not over restrained. These evaluations would typically occur around the same time as the resident's scheduled Resident Assessment Instrument Minimum Data Set (RAI MDS).

Based on a review of the resident's scheduled RAI MDS from the time the restraint was first initiated to present day, the resident should have had 11 Quarterly Review for the Use of Physical Restraint assessments. Only five assessments were completed.

Failure to follow the home's policy on PASD and Restraints by completing quarterly evaluations may have resulted in the resident being unnecessarily restrained.

Sources: resident's clinical records, Personal Assistive Services Device and Restraints policy (9-P-76; May 2013); and interview with the DOC.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
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,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident exhibiting altered skin integrity received a skin assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Rationale and Summary
Ontario Regulations (O. Reg.) 246/22 s. 55 (3) defined altered skin integrity as potential or actual disruption of epidermal or dermal tissue.

A resident had a fall which resulted in two areas of altered skin integrity. An RN completed a skin assessment using the home's Weekly Wound Assessment tool in point click care (PCC) for one area of altered skin integrity. The RN stated that they planned on completing an assessment when the resident returned from the hospital for the other area as the assessment would have changed as a result of the hospitalization. While the RN documented the presence of the second area of altered skin integrity in PCC progress notes, they acknowledged they did not use the home's assessment instrument specifically designed for skin and wound. A wound assessment for the second area of altered skin integrity was completed 12 days after the incident.

The DOC explained that they would expect staff to immediately treat the injury, and complete a skin and wound assessment when the resident had returned from the hospital. The resident returned to the home approximately seven hours after they were initially sent.

Failure to complete a skin assessment using a clinically appropriate assessment instrument specifically designed for skin and wound may have resulted in the resident's wound not being properly assessed when it first occurred, creating a baseline for future assessments.

Sources: resident's clinical records; and interviews with the DOC and other staff.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
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,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee has failed to ensure that a resident exhibiting altered skin integrity received immediate interventions to reduce or relieve pain, promote healing and prevent infection.

Rationale and Summary
A resident had multiple areas of altered skin integrity. The charge nurse documented that the resident was staying in bed more and refusing to get up. Around the same time, the home's physician noted that the resident was declining physiotherapy, refusing to move their leg or get out of bed. The doctor documented that the resident was at high risk of losing more function of lower limbs and becoming bed bound. Progress notes also identified that the resident was experiencing ongoing episodes of pain around that time.

Point of Care (POC) documentation showed that the resident's refusals to be transferred increased. A review of the resident's care plan and task list showed that a turning and positioning every two hours intervention was not initiated until approximately one month after it was noted that the resident was staying in bed more frequently.

The DOC stated that they believed that intervention was initiated earlier.

Failure to receive immediate interventions to reduce/relieve pain and promote healing may have contributed to the resident experiencing ongoing pain and delay in wound healing.

Sources: resident's clinical records; interviews with the Skin and Wound Lead and DOC.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #006 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 an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that a resident exhibiting altered skin integrity was assessed at least weekly, if clinically indicated.

Rationale and Summary

In a five month period, a resident developed multiple areas of altered skin integrity. The resident's electronic treatment administration record (eTAR) specified that the weekly wound assessment were to be completed and indicated the start date for each area. One area did not have a scheduled assessment, despite having a scheduled treatment.

A review of completed weekly wound assessments and skin and wound evaluations determined that assessments/evaluations were not documented a combined 20 times for all the multiple areas of altered skin integrity. The assessments were also not clear if/when a wound had resolved and/or re-opened.

The Skin and Wound Lead explained that weekly wound assessments were clinically indicated for all altered skin integrity and acknowledged that some assessments got missed because the resident would refuse to move and/or allow staff to assess an area. The DOC agreed with the Skin and Wound Lead that all areas of altered skin integrity should have had a weekly wound assessment. The DOC explained that if the resident refused to allow staff to complete an assessment, the task should have been endorsed to the next shift as assessing wound status was clinically important.

Failure to complete weekly wound assessments on areas of altered skin integrity may have resulted in a delay treatment adjustments if/when wounds worsened.

Sources: resident's clinical records; and interviews with the DOC and Skin and Wound Lead.

COMPLIANCE ORDER CO #001 Infection Prevention and Control Program

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

The licensee shall do the following:

1. Ensure that residents are offered and/or supported with performing hand hygiene prior to meals, either in the dining room or in their room.
2. Perform, at minimum, twice weekly resident hand hygiene audits on first floor for a period of six weeks to ensure that resident hand hygiene is consistently being offered and/or supported.
3. Re-educate/train a specific RPN on the home's hand hygiene program, including the four moments of hand hygiene.
4. Perform, at minimum, twice weekly hand hygiene audits, during medication passes, when that RPN administers medication, for a period of six weeks to ensure that hand hygiene according to the four moments of hand hygiene is consistently being performed.

5. Re-educate/train a specific PSW on appropriate personal protection equipment (PPE) selection, application and removal required to enter resident rooms under droplet/contact precautions related to testing COVID-19 positive.
6. Perform, at minimum, twice weekly PPE audits of that PSW selecting, applying and removing PPE required to care for isolated residents under droplet/contact precautions, for a period of six weeks to ensure appropriate PPE selection, application and removal is consistently being done.
7. All required audits are to be documented and identify the person who completed the audit, the audit date, and any actions taken, if required.

Grounds

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Rationale and Summary

A. Section 10.4 (h) and (i), of the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes specified that the home's hand hygiene program shall include policies and procedures to support residents to perform hand hygiene prior to receiving meals, including those who have difficulty to complete hand hygiene due to mobility, cognitive or other impairments. The home's Hand Hygiene policy specified that staff would assist residents with hand hygiene practices before eating, and after coughing or sneezing.

Residents were observed during lunch meal service on first floor. No resident was observed being offered or assisted with hand hygiene, in the dining room or when entering the dining room, prior to receiving their meal.

Six days later, a COVID-19 outbreak was declared on third floor and by the next day had spread to include the first floor as well.

Six days after the start of the outbreak, nine residents, who were not in isolation, were observed during lunch meal service on first floor. No resident was observed being offered or assisted with hand hygiene, either in the dining room or when entering the dining room, prior to receiving their meal. Nine residents who were in isolation due to suspect or confirmed COVID-19, were observed being provided a boxed meal in their room. One resident was openly coughing into their hands multiple times prior to receiving their meal. Another resident began eating their meal with their fingers. None of those residents were offered or assisted with hand hygiene prior to receiving or eating their meal.

The IPAC lead acknowledged that the number of positive cases on first floor was increasing while the third floor remained stable. They also said that residents should have hand hygiene in the dining room prior to meals and for those in isolation, it was expected that hand hygiene would be done prior to receiving or eating their meals.

Failure to offer or assist residents with hand hygiene prior to meals may have contributed to the spread of the infectious disease.

B. Section 9.1 (b), of the IPAC Standard for Long-Term Care Homes specified that at minimum routine practices shall include hand hygiene at the four moments of hand hygiene, including before and after resident contact. The home's policy on hand hygiene identified the moments when staff hand hygiene should be performed, which conformed with the IPAC Standard.

An RPN was observed administering medications to residents during lunch meal service for approximately 20 minutes. During that time, the RPN administered medication to multiple different residents; however, only performed hand hygiene three times when they returned to their medication cart. During that time, they also

touched the computer keyboard, medication cart drawers, medication packets, bottles, plastic spoons, medication cups, keys and the beverage cart.

The IPAC Lead explained that when RNs or RPNs were administering medication, hand hygiene was to be done before leaving the medication cart to administer to the resident and upon their return to the cart, before preparing medication for the next resident.

Failure to consistently perform hand hygiene according to the four moments of hand hygiene may have contributed to the spread of an infectious disease.

C. Section 9.1 (f), of the IPAC Standard for Long-Term Care Homes specified that at minimum, additional precautions shall include additional personal protection equipment (PPE) requirements including appropriate selection, application and removal. The home's Additional Precautions policy stated that for residents positive for COVID-19, PPE required included eye protection, N95 mask, gown and gloves. The policy also dictated that the proper donning order was gown before gloves, and doffing order was gloves before gown.

During the most recent outbreak, staff delivered boxed lunches to residents in isolation, under droplet/contact precautions, positive for COVID-19. One PSW consistently donned gloves before their gown and doffed their gown before the gloves while delivering lunch to five residents. They never changed their surgical mask to an N95 mask prior to entering a resident's room, nor did they put on a new surgical mask upon exiting the room. The PSW also never cleaned their eye protection.

The IPAC Lead stated that they expected staff to don N95 masks when entering residents' rooms who were confirmed positive for COVID-19, change to a surgical mask and clean their eye protection upon exiting the rooms. They stated that the correct order for donning and doffing PPE was gown before gloves and gloves

before gown. The IPAC Lead also confirmed that the spread of COVID-19 on the first floor was increasing, compared to the third floor, which had stabilized.

Failure to appropriately select, apply and remove required PPE, may have contributed to the spread of the infectious disease.

Sources: observations; Hand Hygiene policy (8-P-06; August 2023), Additional Precautions policy (8-P-26, September 2023), IPAC Standard for Long-Term Care Homes (revised September 2023); interviews with the IPAC Lead and other staff.

This order must be complied with by February 7, 2025.

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.