

Inspection Report under the Long-Term Care Homes Act, 2007 Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	_	Type of Inspection / Genre d'inspection
Dec 18, 2013	2013_240506_0006	H-000647- 13	Critical Incident System

### Licensee/Titulaire de permis

MENNONITE BRETHREN SENIOR CITIZENS HOME

1 Tabor Drive, St. Catharines, ON, L2N-1V9

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

MENNONITE BRETHREN SENIOR CITIZENS HOME

1 Tabor Drive, St Catharines, ON, L2N-1V9

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

LESLEY EDWARDS (506)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): December 12 and December 13, 2013

During the course of the inspection, the inspector(s) spoke with The Director, Director of Care(DOC), Assistant Director of Care(ADOC), Registered Nurse(RN), Registered Practical Nurses(RPN) and Personal Support Workers(PSW)

During the course of the inspection, the inspector(s) toured the home, reviewed policies and procedures on falls management, pain and restraints. Conducted a clinical record review and resident observation.

The following Inspection Protocols were used during this inspection: Falls Prevention

Minimizing of Restraining

Pain

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES		
Legend	Legendé	
VPC – Voluntary Plan of Correction	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités	



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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 nonrespect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

- s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
- (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
- (b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants:



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1. A) In the home's Nursing Manual policy Falls Prevention and Management the committee-terms of reference (policy F pages 1-22), indicates that staff is to compete a fall risk assessment in point click care and complete a post fall investigation form (paper copy) when a resident falls. During an interview with registered staff they indicated they were not aware these forms are to be completed after every resident fall. The ADOC confirmed that the registered staff did not complete the fall risk assessment in point click care after resident # 001 fell. The DOC confirmed to her knowledge not all of the registered staff are aware of the post fall investigation form and the need to complete the form after every fall. The DOC indicated that she is currently reviewing this policy and procedure. [s. 8. (1)]

#### 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 be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device Specifically failed to comply with the following:

- s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
- 1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

# Findings/Faits saillants:

1. A)On an identified date in December, 2013, resident # 001 was noted to be wearing a seat belt which was loose fitting and not applied according to manufacturer's guidelines. Interviews with staff on a date in December confirmed that the seat belt was a restraint and could not be removed by the resident. Staff was aware, based on education that they had received, that seat belts used to restrain a resident should be tightened to the distance of approximately 2 finger widths. The seat belt observed was more than 5 inches from the resident's abdomen, which is not in accordance with the manufacturer's guidelines. [s. 110. (1) 1.]



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## 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 be implemented voluntarily.

Issued on this 7th day of January, 2014

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

Lesley Edwards