Ontario

**Ministry of Long-Term Care**

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

**Ministère des Soins de longue durée**

**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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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Dec 20, 2019 | 2019_577611_0041 | 021275-19 | Critical Incident System |

**Licensee/Titulaire de permis**

United Mennonite Home for the Aged
4024 Twenty-Third Street Vineland ON L0R 2C0

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

United Mennonite Home
4024 Twenty-Third Street Vineland ON L0R 2C0

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

KELLY CHUCKRY (611)

## 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): November 21, 22, 27, 28, and 29, 2019.**

**During the course of the inspection, the inspector(s) observed the provision of resident care, reviewed relevant clinical health records, video surveillance, investigative notes, medication incident reports, minutes of relevant meetings, and relevant policies and procedures.**

**During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI)/wound care coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and the Niagara Regional Police.**

**The following Inspection Protocols were used during this inspection:**
**Medication**
**Prevention of Abuse, Neglect and Retaliation**

**During the course of this inspection, Non-Compliances were issued.**
**3 WN(s)**
**2 VPC(s)**
**0 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 19. Duty to protect**

**Specifically failed to comply with the following:**

**s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that all residents were protected from abuse by anyone

and failed to ensure that all residents were not neglected by the licensee or staff.

The home submitted a Critical Incident Report on an identified date pertaining to medication administration, and negligence.

As part of the inspection, the homes investigation file was reviewed, which included video surveillance.

Registered staff #101 was scheduled to work on an identified shift, on an identified day. This staff member took a scheduled break during their shift. During this break, they were observed on video surveillance drinking from a mug in the common area of the home. This same mug was later found in the medication room broken, with alcohol residue evident.

In a telephone interview with staff #106, it was reported that registered staff #101 wasn't quite right after their break. During interview staff #106 acknowledged that they were concerned about the behaviour of registered staff #101. It was further acknowledged that there was a risk to residents on the unit as a result of this behaviour. Staff #106 did not report this behaviour to anyone, despite their concerns, and confirmed that this inaction of reporting this information posed a risk to the safety and well being of residents.

In a telephone interview with staff #105, it was reported that registered staff #101 was observed in a report room upset. Staff #105 further indicated that registered staff #101 was observed in the front entrance area of the home and was stumbling. This was not reported to the Registered Nurse on duty until one hour before the end of the shift. Staff #105 confirmed that not reporting this information immediately was a form of neglect.

A telephone interview was conducted with registered staff #102. During this discussion, it was identified that they were not aware of the behaviour exhibited by registered staff #101 until close to the end of the shift on the date of the incident. During the limited interaction they had with registered staff #101 that shift, there was no evidence of any concerns. Registered staff #102 confirmed that PSW staff were aware of the behaviour exhibited by registered staff #101 and did not immediately report it. It was further confirmed that this was a form of neglect, as residents were at risk.

On the day after the incident, at the time of the investigation, the home was made aware of the following incidences, with respect to the medication management system.

Resident #003, #004, #005, #006, #007, #008, #009, #010, and #011 had medication orders in place to have identified medication(s) administered at an identified time every day.

On the day of the incident, registered staff #102 and #104 identified that the prescribed medications were not administered to the above noted residents.

The home completed a Medication Incident Report and Analysis Form, and documented these incident as medication omissions. The homes investigative notes were reviewed, and further confirmed these medications were not administered.

In an interview conducted with the DOC and the ADOC, it was confirmed that the actions of registered staff #101 placed the residents on an identified unit at risk. It was further confirmed that by staff #105, #106, and #107 did not immediately report the actions of registered staff #101. This inaction, jeopardized the health, safety, and well-being of residents on the unit. [s. 19. (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 ensure that all residents are protected from abuse by anyone and to ensure that all residents are not neglected by the licensee or staff, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The home submitted a Critical Incident Report on an identified date pertaining to medication administration, and negligence.

Registered staff #101 was scheduled to work on an identified shift, on an identified day.

On an identified day, the home conducted an investigation.  At this time, the home was made aware of the following incidences, with respect to the medication management system.

Resident #003, #004, #005, #006, #007, #008, #009, #010, and #011 had  medication orders in place to have identified medication(s) administered at an identified time every day.

On the day of the incident, registered staff #102 and #104 identified that the prescribed medications were not administered to the above noted residents.

The home completed a Medication Incident Report and Analysis Form, and documented these incident as medication omissions. The homes investigative notes were reviewed, and further confirmed these medications were not administered.

An interview was conducted with the ADOC, and further confirmed that the medications were not administered to resident #003, #004, #005, #006, #007, #008, #009, #010, and #11 in accordance with directions for use by the prescriber. [s. 131. (2)]

***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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation**

**Specifically failed to comply with the following:**

**s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that an interdisciplinary team, which included the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who was a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The home submitted a Critical Incident Report on an identified date pertaining to medication administration, and negligence.

Upon request for the 2018 annual evaluation of the effectiveness of the medication management system, the home was not able to provide this information. In an interview conducted with the ADOC, and a subsequent interview with the DOC, it was confirmed that the home did not complete an evaluation of the effectiveness of the medication management system in the home. [s. 116. (1)]

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**Issued on this 20th day of December, 2019**

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

**Original report signed by the inspector.**