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
Mar 8, 2021	2020_857129_0012	013246-20, 022137-20	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

PHYLLIS HILTZ-BONTJE (129), JESSICA PALADINO (586)

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 3, 4, 5 and 6, 2020

The following intakes were inspected:
013246-20 -related to a missing resident
022137-20 - related to abuse

During the course of the inspection, the inspector(s) spoke with a resident, the RAI Coordinator/Wound Care Manager, Behavioural Support Ontario staff, the Director of Care and the Assistant Director of Care.

During the course of the inspection the Inspector made resident observations and observations of a home area, reviewed clinical records, reviewed home's investigative notes, reviewed the Elopement Emergency procedure and reviewed employment records.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for resident #003.

Resident #003 had a history of demonstrating an identified behavior and verbalized their intention to continue to demonstrate the behavior. The written plan of care included a care focus and interventions to reduce risk to the resident when they demonstrate the identified behavior.

A Critical Incident System (CIS) report was submitted to the Director on an identified date in 2020 which outlined the details of an episode when resident #003 demonstrated the identified behavior.

The resident reported that while demonstrating the behavior they fell and received injuries to their hands and knees. The injuries were confirmed by the Wound Coordinator.

Resident #003 had engaged in the behavior for approximately nine hours before staff were aware that the resident had demonstrated the behavior.

Staff did not ensure that environmental safety measures and monitoring of the resident were in place to manage the risks associated to the resident when they demonstrated the behavior and as a result the resident was place at risk and experienced injuries to their hands and knees.

The licensee failed to ensure that the home was a safe and secure environment for resident #003.

Sources: CIS #2951-000006-20, the home's internal investigation notes, the resident's electronic health record, and interviews with the Wound Coordinator, DOC and ADOC. [s. 5.]

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 and ensuring that the home is a safe and secure environment for residents, to be implemented voluntarily.

WN #2: 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 has failed to ensure resident #008 was protected from verbal abuse by a staff member.

Ontario Regulation 79/10, s. 2, defines 'verbal abuse' as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

On an identified date in 2020, the resident reported an incident of verbal abuse by PSW #107, where the PSW made a comment about the resident that was both degrading and served to diminish the resident’s sense of dignity and self-worth.

According to the home's internal investigation notes and interviews conducted with the RAI Co-Ordinator, Behavioral Support Ontario (BSO), Acting Director of Care (ADOC) and Director of Care (DOC), the resident was upset by the incident and fearful of the staff member. Specifically, the resident was afraid to ring their call bell and was experiencing signs of anxiety that they had not demonstrated prior to the incident.

During an interview with the resident, they told the LTCH Inspector that the comments made them feel horrible.

The DOC confirmed the incident of verbal abuse was founded and took action in response to that conclusion.

The inappropriate behavior displayed by the PSW resulted in negative outcome toward the resident, including fear and anxiety. Resident #008 was not protected from verbal abuse by PSW #107.

Sources: CIS Report, the home's internal investigation notes, the home's policy '4.01 Resident Abuse' (last revised September 2018), resident health record, PSW #107's employee file, and interviews with the RAI Co-Ordinator, BSO, ADOC and DOC. [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 and ensuring that residents are protected from abuse by anyone, to be implemented voluntarily.

Issued on this 31st day of March, 2021

[redacted]

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

Original report signed by the inspector.