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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Aug 27, 2021	2021_916168_0002	025839-20, 004369-21, 008117-21, 012528-21, 013106-21	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

LISA VINK (168)

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): August 16, 17, 18, 19, and 23, 2021.

This inspection was completed concurrently with Follow Up Inspection 2021_916168_0001.

This inspection was completed for the following intakes:
025839-20 - related to falls prevention and management;
004369-21 - related to falls prevention and management;
008117-21 - related to falls prevention and management;
012528-21 - related to responsive behaviours and home to be safe, secure environment; and
013106-21 - transferring and positioning techniques.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), assistant DOC (ADOC), Environmental Manager (EM), maintenance staff, a screener, housekeeping staff, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents, and a family member.

During the course of the inspection, the inspector toured the home, observed the provision of care, and reviewed documents, including but not limited to, relevant policies and procedures; investigation notes; temperature logs; training records and clinical health records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

5 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 O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home.

An interview identified that the nursing staff did not measure air temperatures in the home.
Interviews with the maintenance staff identified that air temperatures were measured in the home on a weekly basis.
The temperatures were measured and recorded in hallways and dining rooms in each resident home area.
There were no temperatures measured or documented in two resident bedrooms in different parts in the home since May 15, 2021.
The Weekly Temperature Checks log did not include documentation of temperatures in resident rooms.

Sources: Review of the 2021 Weekly Temperature Checks log and staff interviews. [s. 21. (2) 1.]

2. The licensee failed to ensure that the temperatures required to be measured, including in two resident bedrooms in different parts of the home and in one resident common area on both floors of the home were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

It was reported that nursing staff did not measure air temperatures in the home.
It was identified that maintenance staff measured and documented the temperatures of hallways and dining rooms on all four resident home areas weekly.
A review of the Weekly Temperature Checks log for the time period of April 30, 2021, until August 13, 2021, identified that temperatures were only recorded weekly.
The temperatures were not measured and documented as required.

Sources: A review of the Weekly Temperature Checks log and interviews with staff. [s. 21. (3)]

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 the temperature is measured and documented in writing in at least two resident bedrooms in different parts of the home and that the temperatures required to be measured, including in two resident bedrooms in different parts of the home and in one resident common area on both floors of the home are documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used all equipment or devices, specifically a sling in accordance with manufacturers' instructions when they transferred a resident.

The User Manual identified that slings should be inspected prior to use, that damaged or badly worn slings should be discarded and if the label was illegible the sling was to be removed from service and replaced. Additional direction included that slings should be visually inspected for signs of damage (ie cuts, frays, tears, burns) to the sling straps.

A resident required a mechanical lift, with a sling, for transfers in and out of their bed.
Two PSW staff attempted to transfer the resident with a mechanical lift and a resident dedicated sling.
The transfer was not completed as planned.
Management indicated and PSW staff confirmed that they had received training on how to use mechanical lifts, including slings, in the home within the past few months.
Assessment of the sling following the incident identified that there was no label on the sling and that there was signs of damage.

Staff did not comply with the manufacturers' instructions related to the use of the sling when it was not removed from service and replaced, prior to use.

Sources: Review of User Manual, review of progress notes and assessments for a resident, review of investigation notes, observation of sling(s) and interviews with staff. [s. 23.]

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 staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for a resident that set out the planned care related to interventions in place to maintain their safety.

A resident was identified at risk for falls.
The resident sustained a fall and an injury.
Following the incident they required additional interventions in an effort to maintain their safety.
i. A staff member documented that staff were to toilet the resident if they demonstrated a specific behaviour, and that this was communicated in the communication book, at shift report and a sign posted at the bedside.
It was confirmed that the resident was on a continence management program.
The care plan did not include direction to toilet if the resident demonstrated the behaviour.
A review of the paper clinical health record did not include any written direction which was posted in the resident's bedroom to direct staff related to toileting.
ii. A staff member documented that an intervention was put into place.
The use of the intervention was confirmed by staff.
The use of the intervention was not included in the care plan.

The planned care for the resident specific to toileting when a behaviour was displayed

and the other intervention was included in the progress notes; however, was not set out in the written care plan which all staff were able to access.

Sources: Clinical health record and care plan for the resident and interviews with staff. [s. 6. (1) (a)]

2. The licensee failed to ensure that a resident's plan of care was revised when care in the plan was no longer necessary related to safety checks.

A resident was involved in an incident.
As a result of the incident the resident was to be checked every 15 minutes for a specific time period.
The 15 minute checks were included in the care plan when they were first initiated.
The checks were discontinued after the specific time period, as were no longer required; however, staff continued to monitor the resident just at a lesser frequency.
The care plan was not revised, related to the safety checks, when they were no longer required and the plan was immediately revised to direct staff.

Sources: A review of the progress notes and care plan for the resident and interviews with staff. [s. 6. (10) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1.2) The heat related illness prevention and management plan for the home shall be evaluated and updated, at a minimum, annually in accordance with evidence-based practices. O. Reg. 79/10, s. 20 (1.2).

Findings/Faits saillants :

1. The licensee failed to ensure that the heat related illness prevention and management plan for the home was evaluated and updated, at a minimum, annually in accordance with evidence-based practices.

The home was not able to provide a heat related illness prevention and management plan which was in place and or evaluated and updated in 2020 or 2021.
The policies and procedures provided did not include direction for actions to be taken any day on which the outside temperature forecasted by Environment Canada for the area in which the home was located was 26 degrees Celsius or above at any point during the day or actions to be taken when an area of the home was identified to be above 26 degrees Celsius.

Sources: A review of heat and hot weather related illnesses policies and procedures and an interview with staff. [s. 20. (1.2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee failed to ensure a hand hygiene program was in place in accordance with the Ontario evidenced based hand hygiene program "Just Clean Your Hands" related to staff to assist residents with hand hygiene before and after snacks.

During a morning nourishment pass a PSW was observed to serve six residents beverages and or snacks without immediate prior assistance with hand hygiene.
Staff confirmed that they consistently provided residents hand hygiene assistance prior to and following all meals, but that they had not provided the care prior to the distribution of the nourishment pass.
The home did not have a written program in place for resident hand hygiene at nourishment times.
The Just Clean Your Hands program required that staff assist residents to clean their hands before and after snacks.

Failure to have a hand hygiene program in place in accordance with evidenced based practices presented a minimal risk to residents related to the possible ingestion of disease causing organisms that may have been on their hands.

Sources: Observations of residents during nourishment pass, review of the Just Clean Your Hands program resources and interviews with staff. [s. 229. (9)]

Issued on this 8th day of September, 2021

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

Original report signed by the inspector.