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
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: January 25, 2024
Inspection Number: 2023-1434-0004
Inspection Type: Critical Incident
Licensee: United Mennonite Home for the Aged
Long Term Care Home and City: United Mennonite Home, Vineland

Lead Inspector	**Inspector Digital Signature**
Yuliya Fedotova (632)	Yuliya Fedotova Digitally signed by Yuliya Fedotova Date: 2024.02.05 16:23:05 -05'00'

Additional Inspector(s)
Meghan Redfearn (000765)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 12, 14-15, 18-22, 27-28, 2023, and January 2-4, 2024.

The inspection occurred offsite on the following date: January 9, 2024.

The following intake(s) were inspected:

- Intake: #00097224 related to safe and secure home.
- Intake: #00098243 related to resident care and support services.
- Intake: #00103800 related to falls prevention and management.

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

Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Safe and Secure Home
Infection Prevention and Control
Reporting and Complaints
Falls 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 (1) (a)
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;

The licensee failed to ensure that the written plan of care for a resident set out the planned care for the resident.

Rationale and Summary
The Director of Care (DOC) acknowledged that an identified intervention was started for a resident on a day in December 2023 at specified time, which was not added to the resident's care plan until later on a day in December 2023. The DOC acknowledged the resident was assessed for a need of the identified intervention because of their specified behavior.

Specified home areas' daily assignment sheets, daily shift reports and the resident's

plan of care were reviewed for a specified period of time in December 2023. There was no mention of the specific intervention in place for the resident.

Not having the specified intervention documented in the resident's plan of care posed a risk to the resident that staff not being aware the resident required that intervention.

Sources: Plan of care, daily assignment sheets, daily shift reports; interviews with staff.
[000765]

WRITTEN NOTIFICATION: General Requirements for program - documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
Every licensee of a long-term care home shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee failed to ensure that any actions taken with respect to a resident under a program, including nutrition assessments, reassessments, interventions and the resident's responses to interventions were documented.

Rationale and Summary
Progress notes indicated a resident experienced identified symptoms related to nutrition on two days in August 2023. The Dietary Referrals were completed and sent for nutritional assessments on the same dates in August 2023. The Nutritional Charges Reports, completed by the Registered Dietitian (RD), indicated specified

nutritional interventions trials dated on two dates in August 2023.

The RD stated, once the referral was received, they would assess the resident or sent a referral to the Speech Language Pathologist and this would be documented in progress notes.

The DOC indicated that the referral documentation was to be in the resident's progress notes.

The resident's progress notes and written care plan did not contain documented nutrition assessments and/or interventions and/or the resident's responses to the nutritional interventions related to the dietary referrals sent on two days in August 2023.

Sources: Progress Notes, Care Plan, the Dietary Referrals, the Nutrition Charges Reports; interviews with staff.
[632]

WRITTEN NOTIFICATION: Nutrition Care and Hydration Programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)
Every licensee of a long-term care home shall ensure that the programs include, (c) the implementation of interventions to mitigate and manage those risks.

The licensee of a long-term care home failed to ensure that the nutrition program included, (c) the implementation of interventions to mitigate and manage those risks.

Rationale and Summary

Progress notes indicated that a resident experienced a specified symptom on days in September 2023 and had a specified nutrition intake.

The resident's plan of care did not indicate any dietary referrals submitted to the RD for a nutrition assessment and interventions to manage the resident's specified nutrition intake on or after a day in September 2023.

A nurse indicated that the RD could be contacted via a phone or by completing a digital or a paper form in form of a Dietary referral for a nutritional assessment. If the RD was not available, the registered staff could make changes without the RD by offering food that a resident could eat. Another nurse indicated that for an identified period of time in September 2023, specified nutrition interventions were provided to the resident on their shift.

The Nutrition program in the home did not include the process of implementation of nutritional interventions, such as initiation of dietary referrals for a nutrition assessment to mitigate and manage nutrition risks in residents related to specified nutritional intake.

The Nutrition Manger confirmed that there were no other policies in the Dietary binder in relation to the process of initiation of dietary referrals by the nursing staff to initiate a nutrition assessment and manage nutrition risk for a resident with nutrition concerns.

Sources: Progress notes, PCC documentation, Nutrition policies and procedures binder; interviews with staff.
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WRITTEN NOTIFICATION: Reports re: critical incident

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 1.
Every licensee of a long-term care home shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5): 1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.

The licensee failed to ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5): 1. A resident who had a specified incident in the home.

Rationale and Summary
Progress note indicated that a resident was involved in an incident for a specified period of time.

The DOC confirmed that the Ministry of Long-Term Care was not informed about the incident occurred on a day in December 2023.

Sources: CI Report, progress notes; interview with the staff.
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COMPLIANCE ORDER CO #001 Duty of Licensee to Comply with Plan of Care

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Every licensee of a long-term care home shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1) Ensure that a specified intervention is provided for a resident, when it is indicated in their plan of care.
2) Audit the specified intervention for the resident, when it is indicated in their plan of care, for a period of three weeks.
3) Keep a written record of the audit completed, including dates, names of staff members, who completed the audit and corrective actions taken, if necessary.
4) Educate staff responsible for scheduling the specified intervention on ensuring the unit schedules correlate with the Master schedule and staff are provided directions on what schedule to use for the specified intervention assigned.
5) Educate the nurses, working in a specified home area, on the Responsibilities Policy related to monitoring the duties delegated to the Personal Support Workers, specifically for the specified intervention for the resident.
6) Educate staff, working in the specified home area, on when and where to review staff schedules, how to ensure all staff are present for their shift and their role when a staff member does not arrive for their shift.
7) Keep a written record of the education provided, the dates the training occurred,

names of staff members who attended, and the name of the person, who provided the training.

Grounds
The licensee failed to ensure that the care set out in the plan of care, related to a specified intervention, was provided to a resident as specified in their plan.

Rationale and Summary
A review of a resident's care plan interventions indicated a specified intervention for the resident.

A specified home area's Daily Assignment sheet from a day in December 2023 indicated an agency staff assignment for the specified intervention. Another staff stated the agency staff did not show up to the home area for the shift. The home's investigation notes indicated the agency staff was instructed to go to another home area as per the Master schedule.

The home's management acknowledged there was a miscommunication with the schedules and the Master schedule was not updated.

The DOC acknowledged the Master schedule and the computer schedule did not match, which lead to the agency staff going to the wrong home area on a day in December 2023, and there was no staff to provide the specified intervention for the resident.

The home's staff acknowledged that the daily assignment schedule stated the resident had the specified intervention, so they did not observe the resident.

The Assistant Director of Care (ADOC) acknowledged the intervention was started

on a day in December 2023, but wasn't added to the care plan until later on a day in December 2023.

The Staffing Coordinator acknowledged the resident had the specified intervention on a day in December 2023 but the staff was sent to another home area.

The home's staff acknowledged the resident required the specified intervention and that the agency staff was assigned for that task according to the specified home area's daily assignment sheet on a day in December 2023. Both staff stated that the resident did not have the specified intervention on a day in December 2023.

The nurses' Responsibility Policy stated the floor nurse was to take responsibility for and monitor those duties delegated to the PSWs. The Staffing Coordinator stated the nurse was supposed to know who was working on their unit by looking at the daily assignment schedule.

The floor nurse stated they were not aware the resident had the specified intervention on their shift until after the incident.

The resident was not provided the specified intervention on a day in December 2023, as per their plan of care. This posed harm to the resident because it resulted in negative outcome to the resident.

Sources: Plan of care, the Daily assignments sheets, the nurses' Responsibility Policy, the home's investigation notes, the home's computer and Master schedules; interviews with staff.
[000765, 632]

This order must be complied with by February 7, 2024

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

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.