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

Public Report

Report Issue Date: February 7, 2025

Inspection Number: 2025-1434-0001

Inspection Type:
Complaint
Critical Incident

Licensee: United Mennonite Home for the Aged

Long Term Care Home and City: United Mennonite Home, Vineland

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 28-31, 2025 and February 3-5, 7, 2025

The following intake(s) were inspected:
- Intake #00134426/Critical Incident (CI) #2951-000019-24 - related to falls prevention and management.
- Intake #00131640 - complaint related to admission, absences and discharge.

The following intake(s) were completed during this inspection:
- Intake #00130341/CI #2951-000016-24 - related to falls prevention and management.
- Intake #00132482 - complaint related to admission, absences and discharge.

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

Infection Prevention and Control
Falls Prevention and Management
Admission, Absences and Discharge

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care set out in the plan of care for a resident was documented related to their falls prevention intervention on a specified date. There was no place for staff to document this part of their plan of care. This was corrected in the documentation on February 3, 2025.

Date Remedy Implemented: February 3, 2025

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to the resident when their falls prevention intervention was not in place on a specified date.

Sources: Observation of the resident, staff interviews.

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident received a skin assessment using a clinically appropriate assessment instrument that is designed for skin and wound assessment.

Sources: Resident clinical records, interview with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that a resident who was exhibiting altered skin integrity received a weekly skin assessment using a clinically appropriate assessment instrument that is designed for skin and wound assessment.

Sources: Resident clinical records, interview with staff.

COMPLIANCE ORDER CO #001 When a licensee shall discharge

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 157 (2) (b)
When licensee may discharge
s. 157 (2) For the purposes of subsection (1), the licensee shall be informed by,
(b) in the case of a resident who is absent from the home, the resident's physician or a registered nurse in the extended class attending the resident.

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

1. Educate the Administrator, Director of Care, Associate Directors of Care, and Medical Director on s. 157 (1) and s. 157 (2) of O. Reg. 246/22. The education must be conducted by a member of the licensee's head office; and
2. Keep a record of the education, including the date it was held, who conducted the education and signatures of those who attended indicating they understood the education, for the LTCH inspector to review; and

3. Upon review of the regulations, the Licensee must conduct a thorough review of their Discharge policy, to ensure that it aligns with all regulatory requirements outlined in O. Reg. 246/22 as it pertains to discharges.

Grounds

The licensee has failed to ensure that prior to discharging a resident when they were absent from the home, they were informed by the resident's attending physician that their requirements for care had changed and that, as a result, the home could not provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come into contact with the resident.

A management staff member stated, and the documents reviewed in the inspection, confirmed that the discharge was done by the home while the resident was in hospital and the home was not informed by the physician or a registered nurse in the extended class attending to the resident in hospital.

Sources: Interview with staff, resident clinical records from the home and hospital.

This order must be complied with by March 21, 2025

COMPLIANCE ORDER CO #002 Requirements on licensee before discharging a resident

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 161 (2)
Requirements on licensee before discharging a resident
s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried;

(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident;
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that their wishes are taken into consideration; and
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

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

1. Educate the Administrator, Director of Care, Associate Directors of Care, and Medical Director on s. 161 (2) of O. Reg. 246/22. The education must be conducted by a member of the licensee's head office; and
2. Keep a record of the education, including the date it was held, who conducted the education and signatures of those who attended indicating they understood the education, for the LTCH inspector to review; and
3. Upon review of the regulations, the Licensee must conduct a thorough review of their Discharge policy, to ensure that it aligns with all regulatory requirements outlined in O. Reg. 246/22 as it pertains to discharges.

Grounds

The licensee has failed to ensure that prior to discharging a resident, they

considered alternatives to discharge, collaborated with the appropriate placement coordinator or other health service organizations, kept the resident's POA (Power of Attorney) informed and provided them an opportunity to participate in discharge planning and provided a written notice to the resident.

On a specified date, an incident of responsive behaviours by a resident took place. The resident was transferred to hospital shortly thereafter under the direction of one of the home's management staff.

On the same specified date, a member of the home's management staff spoke with hospital staff by phone and stated the resident was to remain in hospital until a later specified date.

On the following date, the home was contacted by the hospital and informed that the resident was being discharged back to the home. A member of the home's management staff spoke with a Registered Nurse (RN) at the hospital during which the RN was not in agreement with the resident remaining in hospital.

The day after the resident was transferred to hospital, a management staff member contacted the resident's POA by phone and notified them that the resident was discharged from the home.

During an interview with a management staff member, they acknowledged that other management staff were not aware of anything being sent to the POA in writing regarding the discharge.

During an interview with a management staff member, they stated they were unsure if the POA was given the opportunity to participate in discharge planning. They stated they were told by the hospital that they could not speak with a hospital discharge planner and that the home offered to assist the hospital with finding

another arrangement for the resident though the hospital declined. This was denied by the Manager from the hospital who stated that the hospital was willing to have a collaborative discussion with the home though the home did not answer and discharged the resident despite the resident being stable.

No documentation was located that would indicate the home had been in recent contact with any other service organizations prior to the resident's discharge.

When the home failed to ensure that before discharging the resident, the proper legislative requirements were followed, the resident was negatively impacted as they were denied the right to return to the home and left with no permanent accommodation despite being deemed stable and cleared for hospital discharge. The negative impacts extended to the resident's POA who described significant emotional impacts as a result of the resident's discharge.

Sources: Resident clinical and hospital records, interviews with home and hospital staff.

This order must be complied with by March 21, 2025

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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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.