Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d’inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l’inspection	Log # / Registre no	Type of Inspection / Genre d’inspection
Jul 24, 2015	2015_248214_0017	H-002789-15	Resident Quality Inspection

Licensee/Titulaire de permis

MENNONITE BRETHREN SENIOR CITIZENS HOME
1 Tabor Drive St. Catharines ON L2N 1V9

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

MENNONITE BRETHREN SENIOR CITIZENS HOME
1 Tabor Drive St Catharines ON L2N 1V9

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

CATHY FEDIASH (214), KELLY HAYES (583), ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l’inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): July 2, 6, 7, 8, 9, 10, 2015.

Please note: The following inspection's were conducted simultaneously with this RQI: Complaint inspection's H-00279-15, H-002639-15; Critical Incident System inspection H-002574-15 and Follow Up inspection H-002550-15 related to s.6(1)(c).

During the course of the inspection, the inspector(s) spoke with the Director, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Nutrition Manager and Environmental Services Supervisor, Therapeutic Recreation Supervisor & Volunteer Coordinator, Registered staff, Personal Support Workers (PSW's), Registered Dietitian (RD), dietary staff, President of Family Council, residents and families. During the course of this inspection the inspector's reviewed clinical records; relevant policies and procedures; Critical Incident System submission by the home; meeting minutes; the home's complaint logs and observed the provision of resident care.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

13 WN(s)
8 VPC(s)
1 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	Legendé 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. 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. 2007, c. 8, s. 6 (7).

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 each resident that set out clear directions to staff and others who provided direct care to the resident.

A) A review of resident #109's clinical record indicated that they sustained a fall on an identified date in 2015. A review of the resident's written plan of care for falls indicated under interventions, with a revision date in March 2015, to ensure that the resident uses their walker at all times when transferring and walking around in the building. Another intervention under the falls focus with an initiated date in March 2015, indicated that the resident uses their wheelchair most times to go from the bedroom to the dining room, around the unit and off the unit. In the same plan of care under the focus for mobility,

interventions in place with an initiated date in January 2013, indicated that the resident requires a roller walker for all ambulating within the facility. An interview with front line nursing staff indicated that the resident uses their wheelchair most of the time and only uses their walker in their room to go to and from the bathroom. An interview with the RAI Coordinator confirmed that the written plan of care did not set out clear directions to staff and others who provide direct care to the resident. (214)

B) A review of resident #104's toileting plan of care was completed. The toileting focus identified resident #104 required extensive to total assistance from two staff using a lift device for transfers to the toilet and toileting care. The continence focus identified resident #104 was able to walk and transfer onto toilet on their own and required assistance from one staff for toileting care. In an interview with PSW staff on an identified date in 2015, it was confirmed resident #104 required extensive assistance from two staff using the the lift device for transfers to the toilet and toileting care. In an interview with the RAI coordinator on an identified date in 2015, it was confirmed that resident #104's plan of care did not set out clear direction to staff and others who provided direct care to the resident. (583)

C) A review of resident #112's current written plan of care with an identified date in 2015, indicated under toileting that the resident verbalized that they have not used the toilet for 2 months as they had felt too weak and preferred to stand at the bed side with staff assistance to have their incontinent product changed. A second intervention under toileting indicated that the resident required total assistance of one staff. The same written plan indicated under bladder incontinence to encourage and ask the resident if they would like to use the toilet and be toileted. The written plan also indicated under bowel incontinence that the resident will ring the call bell to get up to be toileted on the toilet instead of in their brief, when they can tolerate it and that the resident required extensive assistance of one staff. An interview with front line nursing staff indicated that for approximately one month now, the resident has not stood at the side of their bed to have their incontinent product changed. Front line nursing staff indicated that the resident has had their incontinence needs met by having their incontinent product changed and peri care provided while they are in their bed. An interview with the the RAI Coordinator confirmed that the written plan of care did not set out clear directions to staff and others who provide direct care to the resident. (214) [s. 6. (1) (c)]

2. The licensee failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

A review of the most recent nutrition assessment completed on an identified date in 2015, for resident #113 identified they were on a regular diet texture with cut up foods cut to a specific identified size and had chewing and swallowing difficulties. During an observation of resident #113 on an identified date in 2015, in the dining room they were observed being fed pieces of meat larger than the specific identified size by a family/designate member. A review of the eating plan of care and dietary aid resident diet list did not identify that pieces of food were required to be cut up to the identified specific size. In an interview with the Registered Dietitian (RD) it was confirmed that resident #113's plan of care was not based on the most recent RD assessment. [s. 6. (2)]

3. The licensee failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

It was observed on an identified date in 2015, during lunch service that resident #200 was not eating their lunch. Staff encouraged the resident to eat; however; the resident continued to refuse. After meal service was finished it was observed that the resident was not offered anything else to eat and was removed from the dining room by staff. A review of the resident's current plan of care indicated that staff were directed to make the resident's meal choices for the resident. If the resident does not eat or pushes food away, staff are to offer the resident the alternate meal choice.

It was confirmed by the dietary staff that staff did not offer resident #200 the alternate meal when the resident refused to eat the first meal choice. [s. 6. (7)]

4. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident’s care needs change or care set out in the plan was no longer necessary.

A) A review of resident #105’s admission Minimum Data Set (MDS) coding for section G. Physical functioning and structural problems with an identified date in 2014, indicated that the resident was coded as requiring extensive assistance of two or more person’s for toileting. A review of the resident’s quarterly MDS coding with an identified date in 2015, indicated that the resident experienced deterioration in their physical functioning and now required total assistance of two or more person’s for toileting. A review of the resident’s written plan of care indicated under toileting that the resident required extensive assistance of two or more staff. An interview with the RAI Coordinator confirmed that the resident required total assistance for their toileting needs and that the plan of care was not reviewed and revised when their care needs changed.(214)

B) A review of resident #112’s current written plan of care dated indicated under toileting that the resident verbalized that they have not used the toilet for two months as they have felt too weak and preferred to stand at the bed side with staff assistance to have their incontinent product changed. An interview with front line nursing staff indicated that for approximately one month now, the resident has not stood at the side of their bed to have their incontinent product changed. Front line nursing staff indicated that the resident has had their incontinence needs met by having their incontinent product changed and peri care provided while they are in their bed. An interview with the RAI Coordinator confirmed that the resident was not reassessed and their plan of care reviewed and revised when their care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.
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 plan of care is based on an assessment of the resident and the resident's needs and preferences, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy protocol, procedure, strategy or system was complied with.

A review of the home’s complaint policy titled, Organizational Complaints (dated July 2014) indicated the following:

i) When residents, tenants, family members or visitors speak to a staff member about concerns regarding resident care, treatment, privacy, accessibility or safety they should be referred to the appropriate management staff.

ii) The staff member with whom the concern is shared will ensure a Verbal Complaint Form is completed and will record the concern in the Progress Notes (PN) in Point Click Care (PCC) where the concern is involving a resident in long term care.

An interview with the DOC confirmed that the family of resident #301 had placed a concern to them regarding the care of the resident on an identified date in 2014. A review of the home’s Organizational Complaint Log indicated that this concern had not been documented on the log forms or in PCC. An interview with the DOC confirmed that no documentation was completed on the Verbal Complaint Form or in PCC. An interview with the Director confirmed that the concern had not been logged on the home’s Organizational Complaint Log as was required and that the home did not comply with their policy. [s. 8. (1) (b)]

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 any plan, policy protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, when clinically indicated.

A) Resident #108 was a high risk for altered skin integrity and had multiple identified areas of altered skin integrity to various areas on their body during an identified period of time in 2014. A review of the resident's clinical records indicated that one of the identified areas was assessed on a specific date in 2014, and treatment was provided. This area was not reassessed until 26 days later. Another identified area was also assessed on an identified date in 2014, and treatment was provided. There were no further assessments of this area. On a specified date in 2014, another specified area of altered skin integrity was identified. There were no further assessments of this area. On another specified date in 2014, the resident was assessed by the Wound Care Nurse and it was identified that the resident had multiple alterations in their skin integrity to an identified area on their body. This area was not reassessed until 11 days later.

It was confirmed during an interview with the RAI Coordinator on a specified date in 2015, that the resident's alterations in their skin integrity were not reassessed at least weekly by a member of the registered nursing staff, when clinically indicated.(508)

B) Resident #107 had alterations in their skin integrity on identified areas of their body. A review of the resident's clinical records, indicated that one of the areas was assessed on an identified date in 2015, and then not reassessed until 64 days later. Staff conducted an assessment of the other identified area on a specified date in 2015. The next assessment of this area was conducted 20 days later and following this assessment, the area was next reassessed 17 days later and not weekly when clinically indicated.

It was confirmed by the RAI Coordinator during an interview on a specified date in 2015, that the resident's alterations in skin integrity were not reassessed at least weekly by a member of the registered nursing staff when clinically indicated. [s. 50. (2) (b) (iv)]

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 resident who exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, when clinically indicated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident who demonstrated responsive behaviours strategies were developed and implemented to respond to these behaviours.

Resident #108 was identified as having responsive behaviours which included being resistive to care. A review of the resident's clinical record for an identified period of seven months, indicated that the resident would intermittently refuse medication, meals and nursing care. A review of the resident's plan of care over this period of time, did not identify these responsive behaviours. Strategies had not been developed or implemented to respond to these behaviours and during this period the resident continued to intermittently refuse medications, treatments and meals.

It was confirmed during an interview with the RAI Coordinator on a specified date in 2015, that resident #108 demonstrated responsive behaviours and strategies had not been developed or implemented to respond to these behaviours. [s. 53. (4) (b)]

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 for each resident who demonstrates responsive behaviours strategies are developed and implemented to respond to these behaviours, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents, as a condition of continuing to have contact with residents, received training relating in behaviour management.

During an interview with the DOC on a specified date in 2015, related to staff education and training, it was identified that not all staff who provided direct care to residents received training relating to behaviour management. The DOC indicated that some of the nursing staff, which included registered and PSW staff had received training in 2014, but not all staff who provided direct care to residents.

The DOC confirmed that in 2014 the home had 148 nursing staff working at the home. Out of the 148 nursing staff only 69 had received training relating to behaviour management. It was confirmed by the DOC that not all staff who provided direct care to residents, as a condition of continuing to have contact with residents, received training relating to behaviour management. [s. 76. (7) 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 all staff who provide direct care to residents, as a condition of continuing to have contact with residents, receive training relating in behaviour management, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer’s instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions.

A) During a tour of the home on a specified date in 2015, resident #300 was observed with a safety device applied unsafely. Registered staff confirmed that the resident was unable to unfasten the device. A review of the manufacturer's directions for this safety device indicated that the device must be worn tightly fitted. Registered staff confirmed that the safety device used for this resident was not applied according to the manufacturer's instructions. (214)

B) During a tour of the home on a specified date in 2015, resident #200 was observed with a safety device applied unsafely. The resident was unable to unfasten the device when asked. A review of the manufacturer's directions for this safety device indicated that the device must be worn tightly fitted. Registered staff confirmed that the safety device used for this resident was not applied according to the manufacturer's instructions. (508) [s. 110. (1) 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 the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all direct care staff were provided training in skin and wound care.

During a review of the education provided to direct care staff, it was identified that in 2014, the home offered skin and wound training to only the registered staff and not to all direct care staff which would include PSW's. During an interview with the DOC on a specified date in 2015, they had identified that in 2014, there were a total of 41 registered staff working at the home. Only 21 out of the 41 registered staff received skin and wound care training. None of the 107 PSW's received skin and wound care training in 2014.

It was confirmed during an interview with the DOC that only 21 out of the 148 direct care staff received skin and wound care training in 2014. [s. 221. (1) 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 all direct care staff are provided training in skin and wound care, to be implemented voluntarily.

WN #8: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the Infection Prevention and Control Program.

A) During a tour of the home in room 316, an unlabeled hairbrush with strands of hair in the bristles, was observed in the shared resident bathroom. (214)

B) During a tour of the home in room 317, two toothbrushes and a used bar soap was observed in an unlabeled soap dish in the shared resident bathroom.(214)

C) During stage one of this inspection, it was identified in room 202, in a bathroom shared by two residents, there were three unlabeled toothbrushes laying on the counter. (508)

D) During stage one of this inspection, it was identified in room 216, in a bathroom shared by two residents, a toothbrush and a hairbrush with strands of hair in the bristles were laying on the counter without labels to identify who these items belonged to.(508)

E) During stage one of this inspection, it was identified in room 217, there were two hairbrushes and a denture cup on the counter of the shared bathroom with no labels. (508)

An interview with front line nursing staff confirmed that resident's personal hygiene items should have been labeled in these shared bathrooms to prevent the risk of cross contamination. [s. 229. (4)]

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 staff participate in the implementation of the Infection Prevention and Control Program, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident had fallen, the resident was assessed and when required, a post-fall assessment had been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Resident #201 had a fall on an identified date in 2014, resulting in a injury. A review of the resident's clinical record indicated that a post fall assessment had been conducted by registered staff, however, staff did not use a clinically appropriate assessment instrument specifically designed for falls.

It was confirmed during an interview with the DOC on a specified date in 2015, that the registered staff did not use a clinically appropriate instrument specifically designed for falls to conduct a post fall assessment for resident #201. [s. 49. (2)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents’ Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the advice of the Family Council was sought in development, carrying out the satisfaction survey, and in acting on its results.

During an interview with the chair of Family Council on an identified date in 2015, it was identified that the Family Council had not been involved in developing, carrying out and acting on the results of the satisfaction survey. During an interview with the Director it was confirmed that the licensee did not seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results. [s. 85. (3)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents’ linens are changed at least once a week and more often as needed,
(ii) residents’ personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents’ soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents’ lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, that procedures were developed and implemented to ensure that there was a process to report and locate residents’ lost personal items.

During a family/designate interview for resident #111 it was shared that the resident's visual aid was lost two times in an identified year and reported to staff. In an interview with front line nursing staff on specified dates in 2015, they identified that they were unaware of what process they should have followed to report and locate resident #111's lost personal items. During an interview with the Director on an identified date in 2015, it was confirmed that the home did not have a procedure developed and implemented to report and locate residents' lost personal items. [s. 89. (1) (a)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee failed to ensure that when an incident occurred that caused injury to a resident for which the resident was taken to the hospital and the injury resulted in a significant change in the resident's health condition, the licensee informed the Director of the incident no later than three business days after the occurrence of the incident.

Resident #201 had a fall on an identified date in 2014, that resulted in injury. The resident was transferred to hospital and consequently, had surgery. The resident's condition declined and they were re-admitted back to the home with a significant change in their condition.

It was identified that this incident was not reported to the Director until four days after the resident returned to the home and eleven days after the home was notified of the resident sustaining a injury. The DOC confirmed during an interview that this occurrence should have been reported to the Director within three business days after the occurrence. [s. 107. (3.1) (b)]

WN #13: 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 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, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

An interview with the DOC on a specified date in 2015, confirmed that an interdisciplinary team comprised of the required team members had not met annually to evaluate the effectiveness of the medication management system in the home in either the year’s 2013 or 2014. [s. 116. (1)]

Issued on this 6th day of August, 2015

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CATHY FEDIASH (214), KELLY HAYES (583), ROSEANNE WESTERN (508)
Inspection No. / No de l'inspection :	2015_248214_0017
Log No. / Registre no:	H-002789-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 24, 2015
Licensee / Titulaire de permis :	MENNONITE BRETHREN SENIOR CITIZENS HOME 1 Tabor Drive, St. Catharines, ON, L2N-1V9
LTC Home / Foyer de SLD :	MENNONITE BRETHREN SENIOR CITIZENS HOME 1 Tabor Drive, St Catharines, ON, L2N-1V9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	TIM SIEMENS

To MENNONITE BRETHREN SENIOR CITIZENS HOME, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2015_312503_0009, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that there is a written plan of care for each resident including resident #104, 109 and 112 that sets out clear directions in all areas of the written plan to staff and others who provide direct care to the resident's. The plan is to also include quality systems that will be in place to ensure ongoing compliance. The plan is to be submitted electronically to Long Term Care Homes Inspector Cathy.Fediash@ontario.ca by August 14, 2015.

Grounds / Motifs :

1. A) Previously identified as non-compliant with a CO on May 5, 2015.

B) A review of resident #109's clinical record indicated that they sustained a fall on an identified date in 2015. A review of the resident's written plan of care for falls indicated under interventions, with a revision date in March 2015, to ensure that the resident uses their walker at all times when transferring and walking around in the building. Another intervention under the falls focus with an initiated date in March 2015, indicated that the resident uses their wheelchair most times to go from the bedroom to the dining room, around the unit and off the unit. In the same plan of care under the focus for mobility, interventions in place with an initiated date in January2013, indicated that the resident requires a roller walker for all ambulating within the facility. An interview with front line nursing staff indicated that the resident uses their wheelchair most of the time

and only uses their walker in their room to go to and from the bathroom. An interview with the RAI Coordinator confirmed that the written plan of care did not set out clear directions to staff and others who provide direct care to the resident.(214)

C) A review of resident #104's toileting plan of care was completed. The toileting focus identified resident #104 required extensive to total assistance from two staff using a lift device for transfers to the toilet and toileting care. The continence focus identified resident #104 was able to walk and transfer onto toilet on their own and required assistance from one staff for toileting care. In an interview with PSW staff on an identified date in 2015, it was confirmed resident #104 required extensive assistance from two staff using the lift device for transfers to the toilet and toileting care. In an interview with the RAI coordinator on an identified date in 2015, it was confirmed that resident #104's plan of care did not set out clear direction to staff and others who provided direct care to the resident. (583)

D) A review of resident #112's current written plan of care with an identified date in 2015, indicated under toileting that the resident verbalized that they have not used the toilet for two months as they had felt too weak and preferred to stand at the bed side with staff assistance to have their incontinent product changed. A second intervention under toileting indicated that the resident required total assistance of one staff. The same written plan indicated under bladder incontinence to encourage and ask the resident if they would like to use the toilet and be toileted. The written plan also indicated under bowel incontinence that the resident will ring the call bell to get up to be toileted on the toilet instead of in their brief, when they can tolerate it and that the resident required extensive assistance of one staff. An interview with front line nursing staff indicated that for approximately one month now, the resident has not stood at the side of their bed to have their incontinent product changed. Front line nursing staff indicated that the resident has had their incontinence needs met by having their incontinent product changed and peri care provided while they are in their bed. An interview with the the RAI Coordinator confirmed that the written plan of care did not set out clear directions to staff and others who provide direct care to the resident. (214)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 11, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 24th day of July, 2015

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : CATHY FEDIASH

Service Area Office / Bureau régional de services : Hamilton Service Area Office