Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Oct 7, 2016	2016_434631_0010	014120-15, 020577-15, 031921-15	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

KERRY ABBOTT (631)

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): July 6, 7, 8, 2016

The following inspections were conducted: Critical Incidents; log #014120-15, 025120-15 and 031921-15

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Dietary Manager, registered nursing staff, Personal Support Workers (PSW) and residents.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 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	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. (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 the resident is reassessed and the plan of care reviewed and revised every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

A) A review of resident #001's plan of care prior to June 2015, indicated under "Behaviours" that resident #001 exhibited verbal aggression. A further review of the resident's plan of care indicated that the resident displayed four (4) documented incidents of physical aggression towards resident #002 between April, 2015, and June, 2015. A review of the resident's plan of care dated June 15, 2015, indicated that there was no revision to the plan of care related to any of the goals, nor were interventions implemented in order to manage resident #001's physically aggressive behaviours.

Inspector #631 interviewed staff #100 and staff #101. Both staff confirmed that they were aware that resident #001 had exhibited behaviours such as demonstrating physical aggression towards staff as well as incidents of physical aggression towards resident #002 on several occasions.

An interview with the ADOC on July 8, 2016, confirmed that the plan of care was not revised when the resident #001's care needs changed due to exhibiting physically aggressive behaviours.

Please note: The above-noted non-compliance was identified while conducting Critical Incident Inspection #014120-15 [s. 6. (10) (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 The licensee shall ensure that residents are reassessed and the plan of care reviewed and revised every six months and at any other time that the care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the residents were protected from abuse by anyone and that the residents were not neglected by the licensee or staff.

The home submitted a Critical Incident (CI) report indicating that an incident occurred in July, 2015, in which resident #003 was left in a soiled state for two (2) hours while in bed. The home conducted an investigation in which the home concluded that during safety rounds, staff #104 had discovered resident #003 in a badly soiled state and had intentionally left the resident in this condition. It was reported that at approximately 0830 hours, staff #107 discovered the resident, reported the incident and provided care to the resident.

An interview with the ADOC confirmed that the home's investigation confirmed the above events.

PLEASE NOTE: The above noted non-compliance was identified while conducting critical incident inspection #020577-15 [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance The licensee shall ensure that the residents are not neglected by staff, to be implemented voluntarily.

WN #3: 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 demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

In November 2015, an incident occurred in which resident #004 pushed resident #005 causing injury to resident #005.

A review of resident #004's plan of care indicated that staff had reporteed six (6) incidents in which the resident had shown signs of verbal or physical aggression towards staff and other residents.

An interview with staff #104 confirmed that the resident had several incidents of physical or verbal aggression that involved other residents or staff. Staff #104 confirmed that resident #004 would get agitated and show physical aggression when staff attempted to provide personal care. An interview with staff #103 confirmed that resident #004 was known to show aggressive behaviours, including physical and verbal behaviours with staff and other residents. Staff #103 stated that staff would need to re-approach the resident and reattempt care if the resident was aggressive with them.

A review of the resident's current written care plan indicated that the plan had not included any information regarding the resident demonstrating any physical, verbal or resistive care behaviours. A review of the resident's Minimum Data Set (MDS) Behavioural Symptoms assessment had not included the resident's behaviour of being verbally or physically abusive. An interview with the ADOC on July 8, 2016 confirmed that the resident did demonstrate responsive behaviours of being verbally and physically abusive, and that the MDS Behavioural Symptoms assessment had not included the resident's behaviours of being verbally and physically abusive.

PLEASE NOTE: The above noted non-compliance was identified while conducting critical incident inspection #031931-15 [s. 53. (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 The licensee shall ensure that for each resident demonstrating responsive behaviours, 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., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who are at risk of harm or who are harmed as result of a resident's behaviours including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

A review of resident #001's record indicated that in April 2015, the resident had an altercation with resident #002 and threatened physical aggression towards resident #002. In May 2015, resident #001 had a second altercation with the same resident, in which resident #001 showed physically aggressive behaviours. In June 2015, resident #001 had a third altercation with resident #002 in which resident #001 showed physically aggressive behaviours towards resident #002. On the same date, another incident occurred in which resident #001 exhibited a threatening gesture towards resident #002. A further review of resident #001's records indicated that after the last two incidents occurred, resident #001 was moved to another table in the dining room. According to resident #001's record, no further incidents occurred between resident #001 and resident #002.

Inspector #631 interviewed staff #100 and staff #101. Both staff confirmed that they were aware that resident #001 had shown signs of physical aggression towards resident #002 on several occasions. Both staff confirmed that after the incidents occurred, resident #001 was moved to sit at another table in the dining room and that no further altercations occurred between resident #001 and resident #002.

An interview with the ADOC on July 8, 2016 confirmed that the home was aware of the resident's behaviours and triggers and did not implement interventions to minimize the risk of further altercations between resident #001and resident #002 between April and June 13, 2015, during which four (4) incidents of aggression occurred.

PLEASE NOTE: The above noted non-compliance was identified while conducting critical incident inspection #014120-15 [s. 55. (a)]

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 The licensee shall ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with.

The home had a policy entitled “Resident Abuse”, policy #1.1.13, issued November 17, 2011 and revised in May 2015. Appendix D in the policy stated that “Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm ; the home will report to the MOHLTC immediately upon become aware of the incident” . This policy also stated that "Staff and Administration must report all alleged, suspected or witnessed incidents of neglect of a resident by a staff member of the home".

In July 2015, an incident of abuse/neglect occurred towards resident #003 in which resident #003 was left by staff #106 in a badly soiled state for approximately two (2) hours while in bed. The CI Report submitted by the home indicated that staff #106 neglected to provide care for resident #003 and that staff #107 and #108 had discovered the resident in the soiled stated. The home submitted the CI report, eight (8) days after the incident was reported to the home.

An interview with the Director of Care (DOC) and the Assistant Director of Care (ADOC) confirmed that the home did not follow their policy on “Resident Abuse” and further confirmed the notification to the Ministry of Health and Long Term Care was not submitted immediately.

PLEASE NOTE: The above noted non-compliance was identified while conducting critical incident inspection #020577-15 [s. 20. (1)]

Issued on this 20th day of October, 2016

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

Original report signed by the inspector.