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
Jan 9, 2017	2016_323130_0026	034505-16	Resident Quality Inspection

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

GILLIAN TRACEY (130), CATHY FEDIASH (214)

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): December 15, 16, 19, 20, 21 and 22, 2016.

Please note: The following critical incident inspection was conducted concurrently with this RQI: 027886-16.
During this RQI, staff, residents, families, President of Residents' Council and President of Family Councils were interviewed, clinical records and relevant policies and procedures were reviewed and residents were observed.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator/Wound Care Consultant, registered staff, personal support workers (PSWs), President of Residents' Council, President of Family Council, residents and families.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
5 WN(s)
3 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. (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 the care set out in the plan of care was provided to the resident as specified in the plan.

A) A review of resident #302's current written plan of care indicated that they had medical intervention in place related to a specified diagnosis. The resident's plan of care stated that the medical intervention required a specific treatment at specified times.

A review of the plan of care over a two month period in 2016, indicated that on at least two occasions during that time period reviewed, the medical intervention did not have the required treatment completed.

An interview with the ADOC confirmed that when a treatment was unable to be completed at the time it was scheduled for completion, staff could set a reminder in the electronic treatment administration record (E-TAR) to alert staff on the oncoming shift that the treatment required completion. The ADOC confirmed that they were unable to identify or confirm that a reminder had been set for the resident's scheduled treatment for both of the specified dates and that the plan of care in relation to resident #302's medical intervention had not been provided as specified in their plan.

B) A review of a Critical Incident System (CIS) submitted by the home, indicated that on a specified date in 2016, resident #501 was heard by registered staff #044 to have screamed at staff during a round check. PSW staff #201 indicated that they may have startled the resident during the round check. The CIS indicated that the resident was repositioned but refused to have care provided and staff left the room. The registered

staff was notified a short while later by PSW staff #201 that the resident had an alteration in skin to a specified body part. The registered staff assessed the area and noted the alteration.

A review of the home's investigative notes, as well as an interview with the ADOC, indicated that PSW staff #201 had entered the resident's room to complete a round check, called the resident's name and informed them of the check. The staff proceeded to provide care to the resident while the resident began to demonstrate responsive behaviours towards staff. The staff member indicated that they tried to reassure the resident that they were okay and safe and that the resident began to hit at the staff and that the staff held the resident's hand for a second to stop them from flailing their hands. The staff indicated that the resident had become more upset and that they left the room.

A review of the resident's written plan of care in place at the time of this incident, indicated under the "Behaviour/Mood" focus that staff are not to argue with the resident and to avoid information overload so as to prevent anger and or physical aggression".

An interview with the ADOC confirmed that the care set out in resident #501's plan of care was not provided to them as specified in their plan.

This non-compliance was issued as a result of the following CIS inspection #007640-16. (Inspector #214). [s. 6. (7)]

2. 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 changed.

A) The plan of care for resident #400, indicated the resident required one staff assistance for locomotion in their wheelchair to and from the dining room; however, the resident would self propel around the unit. Staff confirmed the resident could follow simple instruction, such as, "can you lift your feet", before staff portered the resident's wheelchair.

On an identified date in 2016, the resident sustained a fall from their wheelchair, which resulted in injury, while staff were portering the resident. The ADOC confirmed the resident did not have foot rests on, because this allowed the resident to self propel freely and the plan of care did not direct staff to use footrests. The ADOC and the DOC also confirmed the plan of care was not revised after the incident in 2016, to include the use

of footrests after it was identified that there was a potential for future injury when portering the resident without the use of footrests. Please note this non compliance was issued as a result of the following Critical incident inspection: #026656-16. (Inspector #130). [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 to ensure that the care set out in the plan of care is provided to the resident as specified in the plan and to 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 the resident's care needs change, to be implemented voluntarily.

WN #2: 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 a resident had fallen, that the resident had been assessed using a clinically appropriate assessment instrument that was specifically designed for falls.

A) Resident #400 sustained a fall with injury on a specified date in 2016. The resident was sent to hospital where it was confirmed the resident had sustained an injury. The DOC confirmed the resident did not have a post fall assessment completed after the fall, using a clinically appropriate assessment instrument that was specifically designed for falls. This non compliance was issued as a result of the following Critical Incident inspection: #026656-16, which was conducted concurrently. (Inspector #130).

B) Resident #401 sustained a fall with injury on an identified date in 2016. The DOC confirmed that a post-fall assessment had not been conducted after the fall, using a clinically appropriate assessment instrument that was specifically designed for falls. Please note this non compliance was issued as a result of the following Critical Incident Inspection: #028726-16. (Inspector #130). [s. 49. (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 when a resident has fallen, that the resident is assessed using a clinically appropriate assessment instrument that is specifically designed for falls, 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, strategies were developed and implemented to respond to these behaviours, where possible.

A) A review of a Critical Incident System (CIS) submitted by the home, indicated that on a specified date in 2016, resident #500 was demonstrating responsive behaviours. A review of the CIS and the home's investigative notes indicated that PSW #150 approached the resident to provide care; however, the resident resisted. The staff member walked to the resident's room and the resident then followed. While staff #150 was providing care, the resident demonstrated responsive behaviours. Staff #168 then entered the resident's room to provide assistance and the resident then became anxious and began to bang a specified body part onto the arms of the chair. Staff #168 then positioned their hands in a specific manner to minimize the resident from hurting themselves. It was identified the following morning that resident #500 had sustained minor injury to their specified body part.

A review of the resident's quarterly Minimum Data Set (MDS) assessment, dated in 2016, indicated under section "E-Mood and Behaviour Patterns", that the resident was coded as demonstrating responsive behaviours.and that these behaviours were not easily altered.

A review of the resident's plan of care indicated under the focus titled, “Maladaptive Behaviours” that when strategies were not working, staff were to leave the resident and re-approach in five minutes. The date of this intervention was 49 days following the date of the above incident. A second intervention under this focus indicated that the resident responded best to one staff member for care related issues. They demonstrated responsive behaviours when more than one person attempted care. One staff was to use Gentle Pursuasive Approach (GPA), "stop and go" approach for care. The date of this intervention was documented approximately two and a half months following the incident. It was confirmed in the resident's written plan of care and by the ADOC, that no strategies had been developed and implemented to respond to the resident's responsive behaviours, that were known to the staff prior to this incident and prior to the completion of the quarterly MDS review done months earlier.

This non-compliance was issued as a result of the following CIS inspection #027886-16. (Inspector #214). [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 demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee 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. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

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

During stage one of the RQI, resident #303 was observed with a safety intervention in place. The resident was unable to remove the safety intervention when asked.

A review of their current written plan of care indicated that they used a safety intervention at specified times for safety, related to a history of falls.

A review of the documentation in the Point of Care (POC) system, indicated that a task was in place for staff to take specific action related to the safety intervention at specified times. A review of this task over a three day period in 2016, indicated that staff had not documented their action related to the safety intervention, at the specified times and had documented a total of three times in a 24 hour period for each day reviewed. A review of the documentation in POC for hourly checks of the resident while the safety intervention was in place, indicated that a task titled, “Safety Checks” was available. A review of this task during this time period, indicated that the task had not identified that the safety check was to be completed at the specified time and had also not identified what the safety check was for. A review of this task indicated that documentation was completed twice in a 24 hour period on the first identified date, twice on the second identified date and three times on the third identified date in 2016.

During an interview with PSW #097, the staff member confirmed that the specific action required related to the safety intervention in place, was completed at the specified times; however, due to time constraints, they were not always able to document every action taken. An interview with the ADOC indicated that the safety check task in the POC system was not for the purpose of checking the safety intervention at specified times and that the POC documentation system did not have a task set up for staff to document the hourly checks of the resident while the safety intervention was in use.[s. 30. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who was incontinent received an assessment and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

A) The MDS Assessments completed on two identified dates in 2016 for resident #306, indicated the resident had worsening incontinence. The ADOC and the DOC confirmed that an assessment was not conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence when the MDS coding indicated worsening incontinence. (Inspector #130). [s. 51. (2) (a)]

Issued on this 10th day of January, 2017

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

Original report signed by the inspector.