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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 18, 2014	2014_250511_0024	H-001418-14	Resident Quality Inspection

Licensee/Titulaire de permis

CANADIAN REFORMED SOCIETY FOR A HOME FOR THE AGED INC.
337 STONE CHURCH ROAD EAST, HAMILTON, ON, L9B-1B1

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

MOUNT NEMO CHRISTIAN NURSING HOME
4486 Guelph Line, BURLINGTON, ON, L9T-2X6

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

ROBIN MACKIE (511), DIANNE BARSEVICH (581), VALERIE GOLDRUP (539)

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): October 20, 21, 22, 23, 24, 27, 28, 29, 30, 2014

During the course of the inspection, the inspector(s) spoke with residents, family members of residents, Resident Council representative, the Administrator, Director of Care (DOC), registered staff-Registered Nurse(RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW), Health care Aides (HCA), Maintenance Supervisor, Food Service Manager, frontline housekeeping and dietary staff, Life Enrichment Coordinator, Resident Assessment Instrument (RAI) Coordinator and backup RAI Coordinator, Physiotherapist, Physiotherapy Aide, Registered Dietitian.

During the course of the inspection, the inspector(s) toured the home, observed the provision of resident care and services, reviewed relevant resident clinical documents, home policies/procedures/practices, meeting minutes and applicable staff files.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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 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 home did not ensure that the Continence Care policy was complied with.

The home did not follow the "Continence Care Policy", revised January, 2014, which indicated that if there was a change in the resident's health status a Continence Care Assessment Form should be completed. Three residents were reviewed and a Continence Care Assessment form was not completed when a change in their bowel or bladder needs was identified during the resident's quarterly or annual assessment. The Director of Care confirmed the home had not used the assessment tool. [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 the home's Continence Care policy is complied with by completing the home's Continence Care Assessment form when a resident health status changes and a change in their bowel or bladder needs is identified, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that when bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices to minimize risk to the resident.

A) A review of resident #030's written plan of care indicated that they required the use of two quarter bed rails in the raised position for safety, when in bed. On two days in October 2014, the resident was observed in bed with two quarter assist bed rails raised. A review of the resident's clinical health record did not include an assessment of the bed rails being used. The registered staff and DOC confirmed that the home did not have a formalized assessment for the use of bed rails in place. (581)

B) On a day in October 2014, a review of resident #014's written plan of care, provided by the home, indicated that they required the use of two half bed rails in the raised position for bed mobility or transfer, when in bed. A review of the resident's clinical health record did not include an assessment of the bed rails being used. A member of the registered staff confirmed that the home did not have a formalized assessment for the use of bed rails in place. (539)

C) In October 2014, a review of resident #012's written plan of care provided by the home indicated that they required the use of one half bed rail in the raised position for bed mobility or transfer, when in bed. Upon observation the resident had a three quarter rail in place. This was confirmed with the registered staff. A review of the resident's clinical health record did not include an assessment of the bed rail being used. A member of the registered staff confirmed that the home did not have a formalized assessment for the use of bed rails in place. (539) [s. 15. (1) (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 to ensure that when bed rails are used, the resident will be assessed and his or her bed system will be evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices to minimize risk to the resident, 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 has failed to ensure that (b) residents that exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A) A review of a 2014, Minimum Data Set (MDS) quarterly assessment for resident #038 indicated the resident had altered skin integrity. Further review of the clinical record did not indicate a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment was used to assess the wound. Interview with the RN and DOC in October 2014, confirmed that resident #038, who exhibited altered skin integrity, had not received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. (511)

B) A review of a 2014, MDS quarterly assessment for resident #030 indicated the resident had altered skin integrity. Further review of the clinical record did not indicate a clinically appropriate assessment instrument, that was specifically designed for skin and wound assessment, was used to assess the wound. Interview with the RN and DOC in October 2014, confirmed that resident #030, who exhibited altered skin

integrity, had not received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. (511)

C) A review of the 2014, written plan of care for resident #014 indicated that the resident had altered skin integrity. In October 2014, registered staff confirmed that the process for wound treatment involved documenting the care on the Treatment Administration Record (TAR) and completing a weekly skin assessment progress note. In October 2014, The Director of Care confirmed that the home had not used a clinically appropriate assessment tool that was specifically designed for skin and wound assessment. (539) [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that, (b) a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a Registered Dietitian who was a member of the staff of the home.

A review of the February 2014, MDS quarterly assessment for resident #030 indicated the resident had altered skin integrity. Further review of the clinical record did not indicate the resident received an assessment by a Registered Dietitian who was a member of the staff of the home for their wound. Interview with Food Service Supervisor, in October 2014, confirmed resident #030, who had exhibited altered skin integrity in February 2014, was not assessed by a Registered Dietitian who was a member of the staff of the home. [s. 50. (2) (b) (iii)]

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 (b) residents that exhibit altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for a skin and wound assessment and (iii) will be assessed by a Registered Dietitian who is a member of the staff of the home., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 104. Beds allowed under licence

Specifically failed to comply with the following:

s. 104. (1) A licensee shall not operate more beds in a long-term care home than are allowed under the licence for the home or under the terms of a temporary licence issued under section 111 or than are authorized under section 113. 2007, c. 8, s. 104. (1).

Findings/Faits saillants :

1. The licensee did not ensure that they did not operate more beds in the long-term care home than were allowed under the licence for the home or under the terms of a temporary licence issued under section 111 or than were authorized under section 113.

On observation through October 20-24, 2014, there were three suites located in the basement level of the home. It was observed that two residents had each been entering and exiting from these suites independently. Interview with the Administrator confirmed that the home was licensed for 61 beds and that these suites were in addition to the 61 licensed beds. The Administrator confirmed two of the three suites in the basement were presently occupied and rented out to the community. [s. 104. (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 home shall not operate more beds in the long-term care home than are allowed under the licence for the home or under the terms of a temporary licence issued under section 111 or than are authorized under section 113, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee did not ensure that the home was a safe and secure environment for its residents. [s.5]

On October 20, 2014, during the initial tour of the home the supply door was noted to be unlocked. The LTC Inspector observed three bottles of disinfectant cleaner IV in the room which were labeled poisonous and corrosive. Interview with DOC confirmed that the door should be locked at all times and locked the door. [s. 5.]

WN #6: 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 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 and the care set out in the plan was no longer necessary. [6(10)(b)]

A) The plan of care for resident #038 identified a specific way in which they were to be transferred on and off the toilet. Personal Support Workers stated a different method of transfer on and off the toilet. The transfer equipment and the logo was observed in the resident's room. Registered staff stated the current transfer needs of the resident and confirmed that the written plan of care was not updated when the care needs change and the plan was no longer necessary.

B) The plan of care for resident #034 was reviewed and indicated their transfer needs for toileting. The resident was observed on two separate days in 2014, being transferred not as per the plan of care from their wheelchair to the commode in their room. Registered staff and PSW's confirmed that the way the resident was currently being transferred was not as described in the resident's plan of care . The resident's kardex did not describe the current method used for toileting. Registered staff confirmed that the written plan of care was not updated when care needs changed and the plan was no longer necessary. (581) [s. 6. (10) (b)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee did not ensure the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following were satisfied:
1. Alternatives to the use of a PASD had been considered and tried where appropriate.
3. The use of the PASD had been approved by, a Physician, a Registered Nurse, a Registered Practical Nurse, a member of the College of Occupational Therapist of Ontario, a member of the College of Physiotherapist of Ontario, or any other person provided for in the regulations.
4. The use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

Resident #030 was observed in bed with two quarter assist bed rails in the raised position in October, 2014. A review of the clinical record indicated that two bed rails were to be raised for safety. Interview with registered staff and PSW's indicated the bed rails were used for safety and to prevent the resident from falling out of bed. There was no assessment completed to determine the reason for the use of the device, nor any documented consent or approvals for the bed rails use. The RN/RAI Coordinator confirmed that the resident was not assessed to determine if the bed rails were used as a PASD or a restraint and did not have a documented consent or approval for the device in place. [s. 33. (4)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 38. Notification re personal belongings, etc.
Every licensee of a long-term care home shall ensure that a resident or the resident's substitute decision-maker is notified when,
(a) the resident's personal aids or equipment are not in good working order or require repair; or
(b) the resident requires new personal belongings. O. Reg. 79/10, s. 38.

Findings/Faits saillants :

1. The home did not ensure that a resident or the resident's substitute decision-maker was notified when, (a) the resident's personal aids or equipment were not in good working order or required repair.

In a month in 2014, resident #012's personal equipment was noted to have been broken. Upon review of the progress notes there were no indications that the personal equipment had been repaired or replaced. A Physiotherapy Assistant confirmed that the personal equipment needed to be replaced/repaired and the resident had to use another resident's equipment when completing their physiotherapy program. The Physiotherapist confirmed that consent still needed to be obtained from the Substitute Decision Maker to proceed with the replacement process. The Physiotherapist could not confirm that follow-up to proceed had occurred with the Substitute Decision Maker. [s. 38. (a)]

WN #9: 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. (1) The continence care and bowel management program must, at a minimum, provide for the following:
2. Treatments and interventions to prevent constipation, including nutrition and hydration protocols. O. Reg. 79/10, s. 51 (1).

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 did not ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions and where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

A) The MDS annual assessment for resident #014, dated November 2013, indicated the resident had been occasionally incontinent of bowel and frequently incontinent of bladder. The quarterly assessment for resident #014, dated August 2014, indicated the resident was usually continent of their bowel and incontinent of their urine. During a review of the resident's plan of care, a continence assessment could not be located for the resident's change in condition. (539)

B) The quarterly MDS assessment completed for resident #038, dated August 2013, indicated the resident was usually continent of their bowel and incontinent of their bladder. The quarterly MDS assessment completed in November 2013, indicated the resident was usually continent of bowel and now frequently incontinent of their bladder. The quarterly assessment completed in February 2014, indicated the resident was continent of their bowel and frequently incontinent of their bladder. (581)

C) The quarterly assessment completed for resident #034, dated January 2014, indicated the resident was occasionally incontinent of their bowel and incontinent of their bladder. The quarterly assessment completed in April 2014, indicated the resident was continent of bowel and frequently incontinent of bladder.(581)

The Director of Care confirmed that resident #014, #038 and #034 were not assessed using a clinically appropriate assessment instrument that was specifically designed for continence, when the resident's continence status changed. [s.51. (2) (a)] [s. 51. (1) 2.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The home did not ensure that drugs that were stored in an area or a medication cart, were secured and locked.

On a day in October 2014, during the observation of medication administration to resident #042, a registered staff member was observed to enter the resident's room to administer the medication and did not secure the cart in the locked position. A resident went by in a wheelchair during this time and could have accessed the cart. The Director of Care confirmed that it was the expectation of the home that registered staff would lock the medication cart when they leave it. [s. 129. (1) (a) (ii)]

2. The licensee did not ensure that the home complied with the manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting).

On a day in October 2014, while completing a medication review with registered staff, resident #006 and resident #019 had a cream for application located in the Treatment Administration Record Cart. Both creams were expired. Upon review of the clinical record in October 2014, resident #006 did not have a current prescription for use of the cream. Resident #019 had a current prescription and another container of the same cream was located in the cart. [s. 129. (1) (a) (iv)]

WN #11: 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 staff participated in the implementation of the Infection Prevention and Control program.

The home's policy titled Infection Control was last reviewed on January, 2011 and indicated when staff were to wash their hands. This included:
-before and after contact with a patient,
-before preparing, handing, serving or eating food,
-staff must wash their hands before feeding residents in dining room and,
-staff to wash hands after emptying dirty dishes.

During the lunch meal service on a day in October 2014, registered staff and a Personal Support Worker (PSW) were observed to not follow the home's "Infection Control" policy. The staff were observed on numerous occasions to remove soiled dishes from the tables and then serve other food items to residents or assist residents with feeding activities without completing hand hygiene in between the tasks. [s.229(4)] [s. 229. (4)]

2. The licensee did not ensure they participated in the implementation of the infection control program.

On a day in October 2014, while completing a tour of the North Wing's tub area the following items were found in the area without individual labeling: a roll-on antiperspirant and a pink electric shaver which was labeled for "female resident use".

The Director of Care confirmed that resident's should have only received personal care using individually labeled items. The home did not ensure that the items were not shared amongst residents to prevent the spread of infection. [s. 229. (4)]

Issued on this 27th day of November, 2014

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