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

Division de la responsabilisation et de la performance du système de santé
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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
Nov 12, 2015	2015_342611_0013	H-003395-15	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

KELLY CHUCKRY (611), CATHY FEDIASH (214), CYNTHIA DITOMASSO (528)

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 19, 20, 21, 22, 23, 26, 27, 28, and 29, 2015.

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/practises and meeting minutes.

In addition, three complaint inspections were conducted concurrently with this RQI and included: 008539-14, 019446-15 and 025206-15.

During the course of the inspection, the inspector(s) spoke with residents, family members of residents, Resident Council representative, Family 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, front line housekeeping and dietary staff, Life Enrichment Coordinator, Resident Assessment Instrument (RAI) Coordinator and back up RAI Coordinator

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

7 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. (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. (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 the planned care for the resident.

On two identified dates, resident #203 was observed sitting in a wheelchair with a front fastening seat belt. The seat belt was loose, approximately five fingers width from the resident's torso. Interview with PSW #102 and RPN #104 confirmed that the resident was able to physically release the lap belt and it was the residents preference to wear the belt daily. Review of the written plan of care did not include that the resident preferred to wear the lap belt daily when in their wheelchair and was able to physically release the lap belt. Interview with RPN #112 confirmed the daily use of the lap belt should have been included in the resident's written plan of care. [s. 6. (1) (a)]

2. 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 review of resident #020's clinical record indicated that on an identified date, the resident sustained a fall resulting in injury. A review of the resident's written plan of care under the falls focus for interventions indicated that the resident had a bed and chair alarm and that staff were to move the chair alarm between chairs and to ensure that the chair alarm was on and in working order prior to transfers. On an identified date, the resident was observed sitting in their room on a chair with their wheelchair positioned in front of them. The resident's chair alarm was observed to be in place on the wheelchair and activated in the on position.

An interview with staff #119, confirmed that the resident's chair alarm was to be in place underneath the resident while they were sitting in the chair and not left on their wheelchair. [s. 6. (7)]

3. 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 review of resident #020's clinical record indicated that on an identified date, the resident sustained a fall resulting in an injury. A review of the Minimum Data Set (MDS) coding for a significant change in status that was completed on an identified date, for Section G-Physical Functioning and Structural Problems indicated that the resident's status had deteriorated as compared to their status 90 days ago. A review of the ADL (Activities of Daily Living)-Functional Rehabilitation Potential Resident Assessment Protocol (RAP) that was completed on an identified date, for a significant change in status indicated that as a result of a fall that occurred on an identified date that resulted in injury, the resident experienced a number of changes in their ADL status. This narrative RAP indicated that the resident now required extensive assistance in the areas of bed mobility, transfers and toileting; required total assistance with mobilizing in their wheelchair both on and off the unit and now required two staff for all transfers including toileting and bathing.

A review of the resident's written plan of care for an identified period of time, indicated that the resident's plan had not been reviewed and revised to reflect all required changes in their ADL functioning until 26 days from the time of their fall.

An interview with staff #122 and #112, confirmed that the resident's plan of care had not been reviewed and revised when their care needs changed. [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 there is a written plan of care for each resident that sets out the planned care for the resident; 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 when care needs change, to be implemented voluntarily.

WN #2: 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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff when clinically indicated.

Resident #035 was admitted to the home on an identified date. This resident was admitted with three pressure ulcers. Subsequent to the admission, a quarterly review assessment was completed and indicated this resident had a total of seven (7) pressure ulcers.

During an identified period of time, resident #035 was not reassessed at least weekly by a member of the registered nursing staff. Specifically, resident #035 was not fully reassessed a total of eight (8) times. Resident #035 received care as specified in the plan of care for all other areas related to skin and wound care management.

An interview with staff #104 confirmed these weekly reassessments were not completed. A subsequent interview with staff #122 also confirmed these reassessments were not completed. [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 all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds are reassessed at least weekly by a member of the registered nursing staff when clinically indicated, to be implemented voluntarily.

WN #3: 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 has failed to ensure that they did not operate more beds in the long term care home than 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

During the initial tour of the home, it was noted that there are three suites located in the basement level of the home. Two persons who are not residents of the home continue to reside in these suites. Interview with staff #123 confirmed that the home was licensed for 61 beds and that these suites were in addition to the 61 licensed beds. Staff #123 further confirmed two of the three suites in the basement were presently occupied and rented out for a fee to residents in 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 licensee does not operate more beds then what is allowed under the licence for the home. This will include a detailed plan to find alternative living arrangements for those residents that currently exceed what is indicated in the licence., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's physical functioning relating to activities of daily living.

A) A review of resident #002's current written plan of care indicated under bed mobility that the resident required the use of two assist rails for turning and repositioning while in bed.

A review of the home's assessment titled, Bed Rail Risk Assessment which was completed on an identified date, and the most recent assessment completed for this resident was conducted. A review of this assessment indicated that nine questions were asked. The questions asked were related to resident safety with the use of side rails, whether consent was obtained, contributing factors for the resident, and environmental factors associated with the use of side rails. The assessment concluded with whether side rails were recommended and the type of side rails that were to be used. In review of this assessment, there was no question or area for the assessor to respond as to the reason or purpose of the bed rails.

An interview with staff #122 and #112 confirmed that the Bed Rail Risk Assessment did not indicate the reason for use or purpose for the use of bed rails and that the resident's plan of care had not been based on an interdisciplinary assessment of the resident's physical functioning related to the use of bed rails.

B) A review of resident #035's current written plan of care indicated under bed mobility that the resident required the use of two assist rails that resident uses to turn and assist while in bed.

A review of the home's assessment titled, Bed Rail Risk Assessment which was completed on an identified date and the most recent assessment completed for this resident, was conducted. A review of this assessment indicated that nine questions were asked. The questions asked were related to resident safety with the use of side rails, whether consent was obtained, contributing factors for the resident, and environmental factors associated with the use of side rails. The assessment concluded with whether side rails were recommended and the type of side rails that were to be used. In review of this assessment, there was no question or area for the assessor to respond as to the reason or purpose of the bed rails.

An interview with the staff #122 and #112 confirmed that the Bed Rail Risk Assessment did not indicate the reason or purpose for the use of bed rails and that the resident's plan of care had not been based on an interdisciplinary assessment of the resident's physical functioning related to the use of bed rails. (611)

A review of resident #036's current written plan of care indicated under bed mobility that the resident required the use of two quarter rails while in bed.

A review of the home's assessment titled, Bed Rail Risk Assessment which was completed on an identified date and the most recent assessment completed for this resident, was conducted. A review of this assessment indicated that nine questions were asked. The questions asked were related to resident safety with the use of side rails, whether consent was obtained, contributing factors for the resident, and environmental factors associated with the use of side rails. The assessment concluded with whether side rails were recommended and the type of side rails that were to be used. In review of this assessment, there was no question or area for the assessor to respond as to the reason or purpose of the bed rails.

An interview with staff #122 and #112 confirmed that the Bed Rail Risk Assessment did not indicate the reason or purpose for the use of bed rails and that the resident's plan of care had not been based on an interdisciplinary assessment of the resident's physical functioning related to the use of bed rails. (611) [s. 26. (3) 7.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The plan of care for resident #014 and the home's bath schedule identified that the resident required total assistance of two staff to completed a "sling bath" twice weekly, on identified days of the week. Review of Point of Care (POC) documentation during an identified time period revealed that the resident received one bath only. Interview with PSW staff #115, who cared for the resident that day, confirmed that on a specified date, resident #014 did not get their scheduled bath. Registered staff confirmed they were short the bathing PSW and it was the responsibility of the PSW caring for the resident to provide the appropriate hygiene grooming as required. [s. 33. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the dining and snack service included a review of the meal and snack times by the Residents' Council.

Upon review of the Resident Council minutes, it was noted that an opportunity was not provided to Residents' Council to review the times of the dining services as well as snack services provided in the home. An interview with staff #118 confirmed this process was not completed in the home. [s. 73. (1) 2.]

2. The licensee failed to ensure that staff members assist only one or two residents at the same time who needed total assistance with eating or drinking.

On an identified date on an identified resident home area, RPN #100 was observed feeding three residents at the same time. Resident's #200 #201 #202 all required total assistance with meals; at no time, did any of the three resident's attempt to feed themselves. Review of their plans of care confirmed that resident #200 required full assistance with feeding, resident #201 required extensive assistance of one staff, and resident #202 required supervision to total assistance of one staff member. Interview with the RPN confirmed that staff members were to assist one or two residents at the same time requiring total assistance; however, the RPN fed all three residents at the same time. [s. 73. (2) (a)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the required information was posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirement in subsection (3); copies of the inspection reports from the past two years for the long-term care home.

During an initial tour of the home, two inspection reports from 2015 were posted in separate locations in the homes main lobby. Review of the posted reports did not include the Resident Quality Inspection (RQI) Report from 2014. Review of the home's compliance history confirmed three inspection reports were published by the MOHLTC in the past two years, including the 2014 RQI Report. Staff #123 was unable to locate the posted RQI Report from 2014. [s. 79. (1)]

Issued on this 7th day of December, 2015

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

Original report signed by the inspector.