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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 22, 2019	2019_539120_0009	023560-18	Follow up

Licensee/Titulaire de permis

Canadian Reformed Society for a Home for the Aged Inc.
c/o Mount Nemo Christian Nursing Home 4486 Guelph Line BURLINGTON ON L7P 0N2

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

Mount Nemo Christian Nursing Home
4486 Guelph Line BURLINGTON ON L7P 0N2

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): February 15, 2019 (on site) and February 20, 2019 (off site)

An inspection (2018-543561-0007) was previously conducted in May 2018, at which time non-compliance was identified with respect to the licensee's bed safety program. A compliance order #002 was issued in July 2018, with a compliance due date for the end of January 2019. For the follow-up inspection conducted on February 15, 2019, the conditions that were laid out in the compliance order have been met.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Maintenance Co-ordinator and personal support workers.

During the course of the inspection, the inspector toured the home, observed resident bed systems, reviewed resident clinical records, bed evaluation records and maintenance policies, procedures and schedules.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #002	2018_543561_0007	120

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	Légende 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. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to ensure that every window in the home that opened to the outdoors and was accessible to residents could not be opened more than 15 centimeters.

During the inspection, windows in three identified resident rooms were not restricted in any way from opening more than 15 centimeters. The windows were comprised of wood and designed so that they opened outward with the hinge at the top and a crank handle on the side. The windows, when not restricted by a device or mechanism, opened wide enough for a resident to exit through the window. Other identical windows observed in resident rooms had a thin chain link attached with a screw, connecting the moving window component to a fixed window component. The window in one of the identified resident rooms had no chain link and the windows in the other two identified rooms had a chain link that appeared to have been ripped apart.

The maintenance co-ordinator was aware of the requirement for windows to be restricted to 15 centimeters and that their last maintenance audit of the windows was completed in January 2019. According to the audit, an issue was identified with windows in the home, however no notes or comments were made identifying the specific issue.

The licensee did not ensure that every window in the home that opened to the outdoors and was accessible to residents could not be opened more than 15 centimeters. [s. 16.]

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 every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimeters, to be implemented voluntarily.

WN #2: 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:
1. Customary routines. O. Reg. 79/10, s. 26 (3).
2. Cognition ability. O. Reg. 79/10, s. 26 (3).
3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).
4. Vision. O. Reg. 79/10, s. 26 (3).
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).
6. Psychological well-being. O. Reg. 79/10, s. 26 (3).
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).
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).
9. Disease diagnosis. O. Reg. 79/10, s. 26 (3).
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).
11. Seasonal risk relating to hot weather. O. Reg. 79/10, s. 26 (3).
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).
13. Nutritional status, including height, weight and any risks relating to nutrition care. O. Reg. 79/10, s. 26 (3).
14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).
16. Activity patterns and pursuits. O. Reg. 79/10, s. 26 (3).
17. Drugs and treatments. O. Reg. 79/10, s. 26 (3).
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).
19. Safety risks. O. Reg. 79/10, s. 26 (3).
20. Nausea and vomiting. O. Reg. 79/10, s. 26 (3).
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).
22. Cultural, spiritual and religious preferences and age-related needs and preferences. O. Reg. 79/10, s. 26 (3).
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a plan of care was based on, at a minimum, an interdisciplinary assessment of safety risks with respect to the resident.

Three residents who were randomly selected for review did not have a written plan of care that included the safety risks associated with their bed system, and secondly, the nursing staff did not liaise with the maintenance co-ordinator to assess the safety risks with respect to the resident.

Residents #101, #102 and #103, were all provided with a bed system that was equipped with bed rails that could lock into two separate positions. When locked into a horizontal or "transfer" position, the bed rails did not pass entrapment for zone three (between the bed rail and the side of the mattress). The zone was verified to have failed on all three beds by the maintenance co-ordinator, who used a specialized cone and cylinder tool to measure the zone or gap. According to the maintenance co-ordinator, accessories were purchased in January 2019, to be placed into the gap, to minimize the potential for head or limb entrapment. According to RN #001, the maintenance co-ordinator did not communicate with them or other staff who provided care to the residents, that the beds were not safe and secondly, that accessories were installed in order to mitigate those risks.

During the inspection, all three beds were observed to have accessories installed, however, the accessories on beds for residents #102 and #103 were not installed so that they remained secure and in place where required.

The plan of care for all three residents did not include any information or direction about the resident's bed system being unsafe and that accessories were required to be in a particular place in order to mitigate entrapment risks. [s. 26. (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 a plan of care is based on, at a minimum, an interdisciplinary assessment of safety risks with respect to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and O. Reg. 79/10, s. 90 (1).
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that, as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, that there were procedures in place for routine, preventive and remedial maintenance, specifically related to windows.

During the inspection, windows in but not limited to six identified resident rooms were tested for functionality. All of the windows were found to be stuck in an open position, with the keeper partially stuck inside of the lock. The windows were comprised of wood and designed so that they opened outward, like a casement window, but the hinge was at the top and the crank handle on the side of the window. None of the windows could be manipulated to open or close and lock. The crank handle when turned, spun around without affecting the window mechanisms.

A review of the licensee's maintenance policies and procedures did not include any specific procedures to manage or maintain the various types of windows in the home. A schedule was available for all windows to be audited or inspected once per month as part of their preventive maintenance program. According to the "Monthly Maintenance Audit" form (with no year documented on the form), completed by the maintenance co-ordinator in January, windows were found to be in "need of attention or repair". However, a remedial component was not evident. No comments were made as to the specific issue or concern, no specific location was identified (room number) and no plan of action or follow up action was documented.

According to the maintenance co-ordinator, the condition of the windows were known to be an issue. The windows were originally installed incorrectly (the hinge should have been on the side and not the top), were quite old and had been repaired numerous times over the years. Specifically, the cranking mechanism had been replaced for many windows and the wood sash sanded down to allow for the window to glide into the locking mechanism properly. No plans were in place to remedy the window concerns at the time of inspection.

The licensee failed to ensure that, as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, that there were procedures in place for routine, preventive and remedial maintenance, specifically related to windows. [s. 90. (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, as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, that there are procedures in place for routine, preventive and remedial maintenance, to be implemented voluntarily.

Issued on this 4th day of March, 2019

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

Original report signed by the inspector.