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
Mar 26, 2019	2019_543561_0005	008963-18, 023557-18, 023565-18, 023568-18	Critical Incident System

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

DARIA TRZOS (561)

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): March 20, 21, and 22, 2019.

The following Follow Up (FU) inspections were completed during this Critical Incident System (CIS) inspection:
023557-18 - related to abuse and neglect,
023565-18 - related to restraints,
023568-18 - related to medication administration.
The conditions laid out in these compliance orders have been met by the home and the orders will be complied.

A complaint inspection log #025362-18 related to multiple care concerns was completed during this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), registered staff, Personal Support Workers (PSWs), family members and residents.

During the course of the inspection, the inspector observed the provision of care, reviewed clinical records, compliance plan related to orders, policies and procedures, training records and employee files.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
1 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. 112.	CO #003	2018_543561_0007	561
O.Reg 79/10 s. 131. (2)	CO #004	2018_543561_0007	561
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2018_543561_0007	561

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 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).

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.

Resident #001 had a plan of care indicating that they were at an identified risk for falls with a history of identified behaviour. Resident #001's provision of care was observed on several days in 2019. On an identified date in 2019, the resident was observed and an identified intervention was not in place as indicated in the written plan of care. The current written plan of care was reviewed by the Inspector.

PSW #105 was interviewed and also reviewed the kardex for resident #001 and acknowledged the current intervention in place.

In an interview with the Director of Resident Care (DRC), they acknowledged the intervention in the plan of care.

The licensee failed to ensure that the care set out in the plan of care related to a falls intervention was provided to the resident as specified in the plan. [s. 6. (7)]

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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Resident #001 had a plan of care, reviewed and revised on an identified date in 2018, indicating that they required a device for transfers during an identified activity of daily living (ADL). The progress note and the risk management report on an identified date in 2018, indicated that resident #001 was assisted to perform the ADL by two PSWs and the device was not used for the transfer.

In an interview with registered staff #107, they stated that on the identified date in 2018, the device was not used for the ADL as indicated in the plan of care. The registered staff stated that PSW #106 assigned as the primary caregiver to the resident that day, indicated that the device was not used.

The DRC was interviewed and acknowledged that the clinical records indicated that the improper transfer was performed during the ADL for resident #001.

The licensee failed to ensure that the staff used safe transferring when assisting resident #001. [s. 36.]

Issued on this 1st day of May, 2019

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

Original report signed by the inspector.