Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Original Public Report

Report Issue Date: August 11, 2023	
Inspection Number: 2023-1092-0002	
Inspection Type: Proactive Compliance Inspection	
Licensee: Canadian Reformed Society for a Home for the Aged Inc.	
Long Term Care Home and City: Mount Nemo Christian Nursing Home, Burlington	
Lead Inspector Klarizze Rozal (740765)	**Inspector Digital Signature** Klarizze Mae S Rozal Digitally signed by Klarizze Mae S Rozal Date: 2023.08.11 15:00:19 -04'00'
Additional Inspector(s) Sydney Withers (740735)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 20, 21, 25, 26, 27, 28, and 31, 2023 and August 1, 2023.

The following intake(s) were inspected:

- Intake: #00091661 - Proactive Compliance Inspection (PCI)

The following **Inspection Protocols** were used during this inspection:

Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Quality Improvement
Pain Management
Falls Prevention and Management
Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Infection Prevention and Control

Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 3 (1) 18.

The licensee has failed to ensure that every resident had the right to be afforded privacy in caring for their personal needs.

Rationale and Summary
During an initial tour of the home, a wall-mounted tablet used by staff to document care was observed displaying resident personal information (PI) and personal health information (PHI) in a hallway. There were no staff at the screen for a ten-minute period while the information was displayed. A resident and group of individuals touring the home were observed to walk past the screen.

A staff member acknowledged that the tablet should have been locked after use and that PI and PHI should not have been visible when the tablet was not in use. The staff member was observed to lock the screen.

Sources: Observations during initial tour and interview with staff. [740735]

Date Remedy Implemented: July 20, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident was re-assessed, and their plan of care was

revised when their care needs changed.

Rationale and Summary
A resident's plan of care included a specific care schedule. A staff member indicated that the resident had a change in their care schedule. The Resident Assessment Instrument (RAI) Coordinator stated that staff were expected to communicate with registered staff when a resident's care needs have changed. The RAI Coordinator revised the care schedule on the resident's plan of care and communicated with direct care staff about the revisions.

Sources: A resident's clinical record and interviews with staff. [740735]

Date Remedy Implemented: July 31, 2023

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 23 (2) (a)

The licensee has failed to ensure that the home's heat related illness prevention and management plan identified specific risk factors that required staff to regularly monitor and to take appropriate actions in response.

Rationale and Summary
The home's heat related illness prevention and management written plan did not include the identified risk factors that may lead to heat related illnesses for staff to regularly monitor. The Director of Resident Care (DRC) acknowledged that the identified risk factors were not explained in the written plan, and they would revise the plan to include these details. During the course of inspection, the home's heat related illness prevention and management written plan was revised and updated with the identified risk factors.

Sources: Heat Related Illnesses Prevention and Management Plan, resident heat assessments, and interview with the DRC. [740765]

Date Remedy Implemented: July 28, 2023

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 23 (2) (e)

The licensee has failed to ensure the home's heat related illness prevention and management

plan included a protocol for appropriately communicating the heat related illness prevention and management plan to visitors and volunteers.

Rationale and Summary
The home's heat related illness prevention and management plan did not include the written communication protocol of their plan to visitors and volunteers. The DRC acknowledged their communication protocol included staff, residents, families, and the Councils of the home, but did not include the volunteers and visitors. During the course of the inspection, the home's heat related illness prevention and management plan was revised and updated with a written communication protocol to visitors and volunteers and implemented as indicated in the plan.

Sources: Heat Related Illnesses Prevention and Management Plan and interview with the DRC. [740765]

Date Remedy Implemented: August 1, 2023

NC #005 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 168 (2) 6. i.

The licensee has failed to ensure the continuous quality improvement (CQI) initiative report for the fiscal year of 2022 to 2023 contained the written records of the dates actions were implemented and the outcomes of the actions based on the improvements of the home, care, services, programs, and goods.

Rationale and Summary

The home’s CQI 2022 to 2023 initiative report did not indicate the dates of actions implemented and the outcomes based on the improvements of the home. The Administrator acknowledged the dates were not included in the report. During the course of inspection, the report was revised and updated with the dates.

Sources: 2022 to 2023 CQI initiative report, website, and interview with the Administrator. [740765]

Date Remedy Implemented: July 28, 2023

NC #006 remedied pursuant to FLTCA, 2021, s. 154 (2)

O. Reg. 246/22, s. 168 (2) 6. v.

The licensee has failed to ensure the CQI initiative report for the fiscal year of 2022 to 2023 contained the written records of the dates and how actions based on the improvements of the home, care, services, programs, and goods were communicated to the residents, families, Resident's Council, Family Council and the staff of the home.

Rationale and Summary
The home's 2022-2023 CQI initiative report did not outline the dates and how actions based on the improvements of the home were communicated to the residents, families, Resident's Council, Family Council and the staff of the home. The Administrator acknowledged the dates of communication were not included in the report. During the course of inspection, the report was revised and updated with the dates and mode of communication.

Sources: 2022 to 2023 CQI initiative report, website, and interview with the Administrator. [740765]

Date Remedy Implemented: July 28, 2023

WRITTEN NOTIFICATION: Retraining

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)

The licensee has failed to ensure that the persons who have received training under subsection (2) received retraining in the areas mentioned in that subsection at times or at intervals provided for in the Regulations.

Rationale and Summary
FLTCA, s. 82 (2) identified that no staff in the home were to perform their responsibilities before receiving training, including: 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents; and 4. The duty under section 28 to make mandatory reports. The Act defined “staff” as persons who worked at the home as employees of the licensee, pursuant to a contract or agreement with the licensee, or pursuant to a contract or agreement between the licensee and an employment agency or other third party. The Regulations described the intervals for the purposes of subsection 82 (4) of the Act as

annual intervals.

A review of annual staff training records for 2022 and interviews with the DRC and the Office Coordinator indicated that two staff employed by the home did not receive their annual training on the policy and duty outlined in the above paragraph. Additionally, the DRC acknowledged that staff who worked in the home pursuant to a contract or agreement between the licensee and an employment agency did not receive the required annual training in 2022. The home did not have a process in place to ensure staff working in the home pursuant to a contract or agreement received the required annual training.

Failure for the home to provide annual training to the required individuals increased the risk of staff not understanding their responsibilities as set out in the home's policies and training program.

Sources: Annual staff training records and interviews with DRC and Office Coordinator. [740735]

WRITTEN NOTIFICATION: Doors in a Home

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.

The licensee has failed to ensure that all doors leading to stairways and the outside of the home were kept closed and locked.

Rationale and Summary
During an initial tour of the long-term care home (LTCH), a door leading to a stairwell and exit to the outside of the home had a keypad installed; however, the door was unlocked. The door was in a hallway by resident rooms which was accessible to residents passing by. The Administrator acknowledged that the keypad next to the door should unlock the door, that the door was not locked, and they immediately informed the Maintenance Supervisor (MS). The following day, the same door was observed, and a new door handle had been installed. The MS demonstrated that the door was locked and use of a key was required to unlock it.

Failure to ensure that a door leading to a stairwell and exit to the outside of the home was

locked posed a safety and security risk to residents.

Sources: Initial tour of the LTCH, follow-up observation, and interviews with Administrator and MS. [740735]

WRITTEN NOTIFICATION: Air Temperature

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)

The licensee has failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

Rationale and Summary
During the course of inspection, the home was observed to have air temperatures below 22 degrees Celsius in different main rooms, resident rooms, and hallways. The home's July 2023 air temperature records indicated multiple days in the main rooms ranging between 20 to 22 degrees Celsius. The MS acknowledged there were air temperatures below 22 degrees Celsius and stated that some residents have complained of the home being cool.

Failure to ensure that air temperatures were maintained at 22 degrees Celsius, put the resident's comfort at risk.

Sources: Observations, July 2023 air temperature log, and interview with MS. [740765]

WRITTEN NOTIFICATION: Plan of Care

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 11.

The licensee has failed to ensure residents' plan of care were based on an interdisciplinary assessment regarding seasonal risk for heat related illness, including protective measures required to prevent or mitigate heat related illnesses.

Rationale and Summary
The clinical records of multiple residents indicated their heat risk assessments were not

completed annually during the months of May to June. The DRC acknowledged the heat assessments for 2023 were not all completed between May and June as per the home's related illnesses prevention and management plan.

Failure to complete annual heat risk assessments within the set months for May to June, put residents at risk for heat related illnesses.

Sources: Residents' clinical records, Heat Related Illnesses Prevention and Management Plan, and interview with DRC. [740765]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that any actions taken with respect a resident under a program, including interventions and their responses to interventions were documented.

Rationale and Summary
A resident required the use of a specified safety device. Direct care staff were required to complete safety checks on the resident and reposition them at specified times when the device was in place. Task documentation for on an identified date demonstrated that the status of the device, the resident's response and the required repositioning were not documented for a time period of a number of consecutive days. Documentation once per shift within the electronic Medication Administration Record (eMAR) indicated the safety device was in place during that time period. The DRC acknowledged that the task related to the resident's safety device was not available for direct care staff to document under during that time. They indicated that staff did not alert them to the task not being available, therefore no alternative method for documenting the intervention or resident's response was put in place.

Failure for staff to document the required care while the safety device was in place may have impacted staff accountability to ensure the required care was provided.

Sources: A resident's clinical record, task documentation report, and interview with DRC. [740735]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)

The licensee has failed to ensure the home's nutritional care, dietary services, and hydration program was implemented.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee was required to ensure the home's Food Temperature Policy was implemented and complied with. Specifically, staff were required to record food temperatures of all menu items prior to meal service.

Rationale and Summary
The home's food temperatures log for July 2023 identified multiple missing records of food temperatures on different units, dates, and shifts. The Food Service Manager (FSM) #113 acknowledged the missing records and stated that food temperatures were to be measured and recorded prior meal services.

Failure to obtain food temperatures during meal service may have increased the risk of food borne illness for residents.

Sources: Review of the home's July 2023 food temperature log, Food Temperature Policy, and interview with FSM. [740765]