Ontario

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

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

Hamilton District
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Original Public Report

Report Issue Date: July 18, 2024
Inspection Number: 2024-1092-0002
Inspection Type: Complaint Critical Incident
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	**Inspector Digital Signature**
Stephanie Smith (740738)	
Additional Inspector(s) Emily Robins (741074)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 11-12, 15-16, 2024.

The following intake(s) were inspected:

- Intake: #00108924 - Critical Incident (CI): 2577-000002-24 - Infectious Disease Outbreak.
- Intake: #00115065 - Complaint regarding resident abuse & neglect, plan of care, continence care and bowel management, transferring and positioning techniques.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

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)
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee failed to implement any standard or protocol issued by the Director with respect to infection prevention and control.

Rationale and Summary
The Infection Prevention and Control (IPAC) Standard for Long-term Care Homes (Revised September 2023) indicated under section 11.6 that the licensee shall post signage at entrances that lists the signs and symptoms of infectious diseases for self-monitoring as well as steps that must be taken if an infectious disease is

suspected or confirmed in any individual.

The Inspector did not observe signage in place when entering the home. This was brought to the IPAC Coordinator's attention and was remedied on the same day. The IPAC Coordinator indicated this signage had been in place prior, they were not sure when or why it was removed.

Sources: Observations and interview with IPAC Coordinator. [741074]

Date Remedy Implemented: July 11, 2024

WRITTEN NOTIFICATION: Dress

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 44
Dress
s. 44. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with the resident’s preferences, in their own clean clothing and in appropriate clean footwear.

The licensee has failed to ensure that two residents and were dressed appropriately, suitable to the time of day.

Rationale and Summary
A resident's care was observed after lunch on a specified date in July 2024. The resident remained in bed after the care and staff did not fully re-dress the resident. They placed a blanket over the resident.

Another resident's care was observed after lunch on another date in July 2024. They also remained in bed post care and staff did not fully re-dress the resident. They also had a blanket placed over them.

Neither resident had this specified direction in their plan of care for not reapplying clothing after their afternoon care.

Failure to ensure that residents were dressed appropriately, suitable to the time of day had risk to impact the resident's' dignity.

Sources: Observations, residents' plans of care, interview with Director of Resident Care (DRC). [740738]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 103 (a)
Policy to promote zero tolerance
s. 103. Every licensee of a long-term care home shall ensure that the licensee's written policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

The licensee has failed to comply with their Prevention of Abuse & Neglect policy for a resident.

In accordance with Ontario Regulation (O. Reg.) 246/22, s. 11 (1) (b), the licensee is required to ensure that the licensee's written policy under section 25 of the Act to

promote zero tolerance of abuse and neglect of residents contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected and must be complied with.

Specifically, staff did not comply with the policy "Abuse & Neglect of Residents: Preventing, Reporting, and Elimination", last reviewed June 26, 2024.

Rationale and Summary
On a specified date in April 2024, there was an allegation of abuse by a direct care staff to a resident. The resident was assessed to have no injuries and the home immediately investigated the allegation. The abuse was unsubstantiated.

The home's Prevention of Abuse & Neglect policy stated that registered staff were to complete a physical exam of the resident to determine any injuries and was responsible for documenting the assessment in the resident's chart within the electronic health record. The resident's chart was reviewed and there was no documentation of the assessment or of the alleged abuse. The DRC acknowledged that staff should have documented their assessment of the resident.

Failure to ensure that staff documented their assessment had risk for incorrect resident records in the event that an injury related to the incident appeared at a later time.

Sources: Resident's clinical records, the home's policy "Abuse & Neglect of Residents: Preventing, Reporting, and Elimination", interview with DRC. [740738]