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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: December 29, 2023	
Inspection Number: 2023-1092-0004	
Inspection Type: 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 Daniela Lupu (758)	**Inspector Digital Signature** Daniela Lupu Digitally signed by Daniela Lupu Date: 2024.01.11 16:32:20 -05'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: December 5-8, 12-15, and 18, 2023
The inspection occurred offsite on the following date: December 19, 2023

The following critical incidents (CI) intake(s) were inspected:

- Intake #00022230, and #00096969, related to abuse
- Intake #00098478, related to falls prevention and management.

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

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. 115 (5) 4. ii.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
ii. the long-term actions planned to correct the situation and prevent recurrence.

The licensee failed to ensure that the critical incident (CI) report related to a resident's fall included the long-term actions to prevent recurrence.

Rationale and Summary

A CI related to a resident's fall resulting in transfer to the hospital and a change in their condition was received by the Ministry of Long-Term Care (MLTC).

After the resident's return from the hospital, their plan of care was revised to include the long-term actions to prevent recurrence, however, the CI report was not amended with these actions until after the inspector's discussion with the Director of Resident Care (DRC).

Sources: a critical incident report, a resident's clinical records and an interview with the DRC. [758]

Date Remedy Implemented: December 18, 2023

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
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.

The licensee has failed to ensure that the care set out in a resident's plan of care for falls prevention was provided to the resident as specified in the plan.

Rationale and Summary

A resident's plan of care for falls prevention documented that specific interventions were to be in place to mitigate the resident's risk for falls.

On one occasion, one of the falls prevention interventions was not in place as

specified in the resident's plan of care. The resident had a fall, sustained an injury and had a change in their condition.

On two separate occasions during this inspection, a different falls prevention intervention was not provided as indicated in the resident's plan of care.

The DRC said staff should follow the falls prevention interventions as indicated in the resident's plan of care.

By not ensuring that the resident's falls prevention interventions were provided as specified in the resident's plan of care, staff may not be able intervene in a timely manner to mitigate the risk for falls, and it may have contributed to the resident's fall and injury.

Sources: observations of a resident's falls prevention interventions, a critical incident report, a resident's clinical records and interviews with PSWs, an RN and the DRC. [758]

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from abuse.

Rationale and Summary

A resident needed assistance from staff members for all their care and mobility needs. On one occasion, the resident was discovered with injuries of unknown cause.

Staff assigned to the resident home area were not aware when the incident happened as they left the home area unattended.

Leaving the resident home area unattended increased the risk that harmful interactions may occur between residents as staff could not intervene in a timely manner.

Sources: a critical incident report, three residents' clinical records, the home's investigation notes, and interviews with a PSW, an RN, the DRC and other staff. [758]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with for a resident.

Rationale and Summary

The home's written policy to promote zero tolerance of abuse and neglect of residents documented that incidents involving physical injury or harm or that caused distress to the resident required immediate notification. If the incident occurred on a weekend or after-hours, the Administrator or DRC needed to be phoned at home. When the allegation was against an employee, the implicated employee would be immediately suspended with pay pending further investigation.

An RN was informed of an incident of alleged abuse of a resident and received a request not to have the alleged staff provide care to the resident.

The RN did not immediately inform the Administrator or the DRC of the allegations. Although the alleged staff did not provide care to that resident, they continued to work at the home and provide care to other residents on the day the alleged abuse was reported.

The Administrator said the RN should have notified the DRC or them immediately and the alleged staff should have been off work pending the investigation.

By not following the home's policy, the risk to other residents was not mitigated as the alleged staff continued to work in the facility on the day the incident of alleged abuse was reported.

Sources: a critical incident report, a resident's clinical records, the home's investigation records, the home's Abuse and Neglect Prevention Program policy and interviews with an RN, the DRC, the Administrator and other staff. [758]

WRITTEN NOTIFICATION: Reports of investigation

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 27 (2)
Licensee must investigate, respond and act
Reports of investigation
s. 27 (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

The licensee has failed to ensure that the results of the investigation of a resident's alleged abuse were reported to the Director.

Rationale and Summary

A CI related to an incident of alleged abuse of a resident was reported to the MLTC.

The home completed the investigation of the incident approximately a week later, but the results of the investigation were not reported to the Director.

Failing to report the results of the investigation of abuse to the Director, limited the Director's ability to respond to the incident, if required.

Sources: a critical incident report, the home's investigation records and an interview with the Administrator. [758]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following

has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident immediately reported it to the Director.

In accordance with FLTCA, 2021, s. 154 (3), the licensee is vicariously liable for a staff member failing to comply with subsection 28 (1).

Rationale and Summary

A PSW was aware of an incident of alleged abuse of a resident. The PSW did not report the incident to the registered staff or to their supervisor.

The following day, an RN was informed about the same incident of alleged abuse of a resident.

The DRC or the Administrator were not immediately made aware of the incident. The incident was not reported to the Director until one day later, when the Administrator received a written complaint alleging abuse of the same resident.

By not reporting the incident of alleged abuse immediately to the Director, it may delay the Director's ability to respond to the incident in a timely manner.

Sources: a critical incident report, a resident's clinical records, the home's investigation records and interviews with an RN, the DRC, the Administrator, and other staff. [758]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that interventions provided to two residents under the Skin and Wound program were documented.

Rationale and Summary

A. A resident had multiple skin concerns. Registered nursing staff were to document the treatment provided and monitoring of the skin concerns on the electronic treatment administration record (eTAR).

The resident's eTAR in a specific month, did not include any documentation to indicate when the treatment was provided to the affected skin areas. Additionally, there was no documentation for monitoring of the resident's affected skin areas.

An RPN said that on multiple occasions, they completed the treatment for the resident's areas of skin concerns, but did not document it.

B. In a two-month period, a resident's eTAR, did not include any documentation to indicate if treatment was provided for the resident's areas of skin concerns until

approximately one month later, when it was documented that all skin concerns were resolved.

The DRC said that treatments and monitoring of residents' skin concerns should have been documented in the residents' eTAR.

By not documenting the interventions provided for the two residents, staff may not be aware when the treatments were to be provided and made it difficult to evaluate the progress of the affected areas and the effectiveness of the interventions.

Sources: two residents' clinical records, and interviews with an RPN and the DRC. [758]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that two PSWs used safe transferring techniques when they assisted a resident with transfers.

Rationale and Summary

A resident needed assistance from staff members for all their transfers and when needed, a mechanical device was to be used.

Two PSWs did not use safe transferring techniques when they assisted the resident with transfers. The resident was injured.

The DRC said staff should have used a higher level of assistance, such as a mechanical device, to complete the resident's transfer, and report changes in transfer status to the registered nursing staff.

Not using safe transferring techniques when assisting a resident with transfers, resulted in injuries to the resident.

Sources: a critical incident report, a resident's clinical records, the home's investigation notes, and interviews with a PSW, an RN, the DRC and other staff. [758]

WRITTEN NOTIFICATION: Falls prevention and management

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident had fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary

A resident had a fall and sustained an injury. A risk management assessment was used to assess the resident post fall. However, this assessment was not part of the resident's clinical records.

The DRC acknowledged that the home did not have a clinically appropriate tool for post fall assessments that was included in the resident's clinical records.

By not ensuring that the risk management assessment post fall was part of the resident's clinical records, information would not be shared as required.

Sources: a critical incident report, a resident's clinical records, risk management report and interviews with an RPN, an RN and the DRC. [758]

WRITTEN NOTIFICATION: Skin and wound care

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (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,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee has failed to ensure that two residents' areas of skin concerns were assessed weekly by a member of the registered nursing staff.

Rationale and Summary

A. A resident had multiple areas of skin concerns. The resident's care plan documented that skin assessments were to be completed weekly to evaluate the effectiveness of the treatments.

Weekly skin assessments were not completed as required for three of the resident's areas of skin concerns. Additionally, two skin assessments were incomplete as they did not include the required details of the skin concerns.

Sources: a resident's clinical records, and interviews with an RPN, and the DOC.

B. A resident's areas of skin concerns were to be assessed weekly until resolved.

There were no weekly skin assessments completed for these skin areas after the initial assessment, and until approximately a month later when it was documented that the skin concerns were resolved. Additionally, the initial skin assessments were incomplete as they did not include the required details listed in the skin assessments.

The DRC said skin assessments should be completed weekly until the affected areas healed and should include as much details as possible, including size, location, description of the skin concern, pain tolerance and progress of the affected skin areas.

Gaps in the completion of skin assessments increased the risk that the progress of the skin concerns and effectiveness of the treatment could not be evaluated, and appropriate interventions may not be implemented if the affected skin areas were to deteriorate.

Sources: a critical incident report, a resident's clinical records, and interviews with

the DRC. [758]

WRITTEN NOTIFICATION: Behaviours and altercations

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations
s. 60 (a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

The licensee has failed to ensure that procedures to minimize the risk for altercations and harmful interactions between and amongst residents were implemented for a resident.

Rationale and Summary

A resident had a history of responsive behaviours towards other residents and staff and their behaviours were unpredictable and not easily altered. Staff were to monitor the resident and intervene as necessary to manage the resident's responsive behaviours.

The home area where the resident resided was not to be left unattended due to residents' behaviours.

A PSW left the resident home area without notifying the RN in charge or the other PSWs.

The resident had an incident of altercation with a co-resident. A different resident was found with injuries of unknown case.

Staff could not determine when and how the resident obtained the injuries, but suspected the resident with known responsive behaviours.

The DRC said the procedure for the resident home area where the above residents resided required that at least one staff member was present to supervise the residents due to the level of unpredictable responsive behaviours of the residents.

Not implementing the procedure related to the continuous supervision of the resident home area, put the residents at risk for harm, as staff could not intervene in a timely manner to minimize the risk of harmful interactions between and amongst residents.

Sources: a critical incident report, three residents' clinical records, the home's investigation notes, and interviews with a PSW, two RNs, the DRC and other staff. [758]

WRITTEN NOTIFICATION: Complaints — reporting certain matters to Director

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 111 (1)
Complaints — reporting certain matters to Director
s. 111 (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 28 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 108 (1).

The licensee has failed to ensure that a copy of the response letter to a complaint alleging abuse of a resident was submitted to the Director.

Rationale and Summary

The home received a written complaint alleging abuse of a resident.

A response letter to the complainant was provided approximately one week later, but the letter was not submitted to the Director.

The Administrator acknowledged that the response letter to the complaint was not provided to the Director, as required.

By not submitting the response letter to the written complaint alleging abuse of a resident, the Director could not respond to the complaint in a timely manner, if required.

Sources: a critical incident report, a written complaint record, the home's investigation notes and an interview with the Administrator. [758]