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: July 30, 2024	
Inspection Number: 2024-1296-0002	
Inspection Type: Complaint Critical Incident	
Licensee: Mirdem Nursing Homes Ltd.	
Long Term Care Home and City: Victoria Gardens Long Term Care, Hamilton	
Lead Inspector	**Inspector Digital Signature**
Additional Inspector	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: July 17, 18, 19, 22, 23, 24, and 25, 2024.

The following intakes were inspected:
·Intake: #00113596 - Falls prevention and management.
·Intake: #00114168 - Complainant regarding resident oral care, nutrition care and hydration programs, bathing, nail care, falls prevention and management, positioning, and hygiene and grooming.
·Intake: #00117001 - Transferring and positioning techniques.

The following intake was completed during this inspection:
·Intake: #00114611 - Falls prevention and management.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Reporting and Complaints
Falls Prevention and Management

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: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident

The licensee has failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

Rationale and Summary
A resident was at nutritional risk and required assistance with eating.
The resident was assessed by an external service provider who made a recommendation for care.

The written plan of care, including the care plan and kardex, did not include the recommendation.
Staff confirmed the recommendation was planned care for the resident; however, had not been added to the written plan of care.
Failure to include the recommendation in a written plan of care increased potential for the resident to not receive care consistent with their needs.
On July 24, 2024, the recommendation was added to the resident's written plan of care.

Sources: A resident's care plan and assessment and an interview with staff.

Date Remedy Implemented: July 24, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident

A. The licensee has failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary
Staff identified that a resident required a level of assistance for all transfers.
During the inspection, the resident's care plan was reviewed. One section of the plan stated they required a level of assistance; however, another section noted they

required a different level of assistance.
Staff acknowledged the written plan of care did not provide clear direction.
Failure to ensure the care plan provided clear direction increased potential for unsafe transfers.
On July 24, 2024, the plan of care was revised related to the resident's transfer status.

Sources: A resident's care plan and transfer assessment and interview with staff.

Date Remedy Implemented: July 24, 2024

B. The licensee has failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary
A resident required staff assistance to meet their oral care needs.
A document identified oral care was to be provided twice a day; however, the care plan directed staff to provide the care at a different frequency.
The plan did not specify the specific oral care supplies to be used.
On July 22, 2024, the care plan and document was revised to reflect oral care at the desired frequency as well as the supplies to be utilized.

Sources: Plan of care for a resident and interviews with staff.

Date Remedy Implemented: July 22, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary

A. The licensee has failed to ensure that a resident was reassessed and their plan of care was reviewed and revised when their care needs changed.

Rationale and Summary
A resident was observed to utilize a device when drinking.
Their plan of care did not list the device as an intervention.
Staff confirmed use of the device to assist the resident.
Staff confirmed the resident had not been assessed for the use of the device.
On July 24, 2024, the resident was reassessed and their plan of care was revised to provide the device at meals and snacks.

Sources: Observation of a resident and review of the care plan and interviews with staff.

Date Remedy Implemented: July 24, 2024

B. The licensee has failed to ensure that the plan of care for a resident was reviewed and revised when the resident's care needs changed, or care set out in the plan was no longer necessary.

Rationale and Summary
A resident was at risk for falls.
The care plan included interventions and strategies in an effort to prevent falls or minimize injury.
Two of the identified interventions were no longer current due to a change in needs.
On July 22, 2024, the plan was reviewed and revised when the two interventions were removed.

Sources: Observation of a resident, review of the progress notes and plan of care for the resident and interviews with staff.

Date Remedy Implemented: July 22, 2024

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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 the plan of care was provided to a resident as specified in the plan.

Rationale and Summary
A resident was at risk for falls.
Their care plan noted they required a device at all times.
The resident was observed unsupervised without the device in place for approximately 10 minutes until it was applied by staff.
Failure to use the device had potential to increase risk of harm to the resident due to

their risk.

Sources: A resident's care plan, observations of the resident and interview with staff.

WRITTEN NOTIFICATION: Compliance with manufacturers' instructions

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The licensee has failed to ensure that staff used all equipment in accordance with manufacturers' instructions.

Rationale and Summary
An Instructions for Use Manual for a device identified use of an accessory to support residents.
A resident used the device and staff failed to apply the accessory as per the manufacturer's instructions.

Sources: Review Instructions for Use Manual, review of Critical Incident Report and staff statements and interviews with a resident and staff.

WRITTEN NOTIFICATION: Bathing

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 37 (1)

Bathing

s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that a resident was bathed by the method of their choice.

Rationale and Summary

The plan of care for a resident identified their preferred method of bathing.
A review of the point of care bathing records identified that the resident was consistently provided a different method of bathing.
Failure to not bathe a resident by a method of their choice had the potential for resident and/or family dissatisfaction.

Sources: A review of bathing records and plan of care for a resident and interviews with staff.

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 77 (5)

Menu planning

s. 77 (5) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 246/22, s. 390 (1).

The licensee has failed to ensure that a planned menu item was offered and available at each meal.

Rationale and Summary

A resident had a planned menu item to receive one serving of an identified food three times a day.
During observations the resident did not receive the specific food item.
Staff reported the item was not available, in error.
Staff confirmed the food was a planned menu item for the resident.

Sources: A resident's care plan, observations during meals and interviews with staff.

WRITTEN NOTIFICATION: Dealing with complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

Dealing with complaints

s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

3. The response provided to a person who made a complaint shall include,

i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to ensure that a response provided to a complainant, included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the Patient Ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary
A complaint was made to the home.
The home provided a response to the complainant; however, due to the use of an outdated form they were not provided with contact information for the Ministry or the Patient Ombudsman.
Failure to provide complainants with all required information had the potential for the complainant not be aware of other avenues to voice concerns.

Sources: Review of complaints binder, logs and Resident and Community Concern and Complaint Form, and interviews with staff.