



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Rapport d'inspection 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**

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de
Hamilton
119 rue King Ouest 11^{ième} étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 1, 2017	2017_570528_0013	004819-17, 004820-17, 004822-17, 004823-17	Follow up

Licensee/Titulaire de permis

HALDIMAND WAR MEMORIAL HOSPITAL
206 JOHN STREET DUNNVILLE ON N1A 2P7

Long-Term Care Home/Foyer de soins de longue durée

EDGEWATER GARDENS LONG TERM CARE CENTRE
428 BROAD STREET WEST DUNNVILLE ON N1A 1T3

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

CYNTHIA DITOMASSO (528)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 13, 18, 19, 20, 2017

This inspection included follow up inspection log #004819-17 related to mandatory training, 004820-17 related to fall prevention, 004822-17 related to continence care and bowel management, and 004823-17 related to safe transferring and positioning; and was completed concurrently with complaint inspection # 2017_570528_0014

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Business Office Manager/Scheduler, Food Service Supervisor (FSS)/ Director of Housekeeping and Laundry, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), residents and families.

During the course of the inspection, the inspectors also observed the provision of care and services, reviewed relevant documents including but not limited to, clinical health records, policies and procedures, investigation notes, staffing schedules, and complaints log.

**The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Personal Support Services
Training and Orientation**

During the course of this inspection, Non-Compliances were issued.

**1 WN(s)
0 VPC(s)
1 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 # / DE L'INSPECTION	NO	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 36.	CO #004	2016_341583_0022		528
O.Reg 79/10 s. 49. (2)	CO #002	2016_341583_0022		528
O.Reg 79/10 s. 51. (2)	CO #003	2016_341583_0022		528



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 76. Training



Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

- 1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).**
- 2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).**
- 3. Behaviour management. 2007, c. 8, s. 76. (7).**
- 4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).**
- 5. Palliative care. 2007, c. 8, s. 76. (7).**
- 6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).**

Findings/Faits saillants :



1. The licensee failed to ensure that all staff who provided direct care to residents, as a condition of continuing to have contact with residents, received training in the following areas:

1. Abuse recognition and prevention
2. Mental health issues, including caring for persons with dementia
3. Behaviour management
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations
5. Palliative care
6. Any other areas provided for in the regulations

A. The licensee failed to ensure that staff received annual training in all the areas required under subsection 76(7) of the Act in accordance with Ontario Regulation 79/10 s. 221(2)(1).

In December 2016, the home was issued a compliance order directing the home to ensure that all direct care staff received training related to minimizing of restraining in accordance with the Act and the regulations. Review of the home's "Staff Sign Off Sheet for Restraints Education", dated February 2017, and interview with the DOC confirmed that approximately 20 percent (%) of direct care staff had received training related to minimizing of restraining.

B. The licensee failed to ensure that the staff received training based on their assessed needs, in accordance with Ontario Regulation 79/10 s. 221(2)(2).

In December 2016, the home was issued a compliance order to ensure that all staff use safe transferring and positioning techniques when assisting residents. Specifically, the licensee was directed to educate all PSW staff on all equipment used for transferring and positioning, with a compliance date February 28, 2017.

Interview with the DOC revealed that as of April 20, 2017, the home had not ensured that any PSW staff were re-educated on safe use of equipment in the home, as required as part of the compliance order. (528) [s. 76. (7)]



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Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 8th day of May, 2017

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

Original report signed by the inspector.



Ministry of Health and
Long-Term Care

Ministère de la Santé et
des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : CYNTHIA DITOMASSO (528)

Inspection No. /

No de l'inspection : 2017_570528_0013

Log No. /

Registre no: 004819-17, 004820-17, 004822-17, 004823-17

Type of Inspection /

Genre

d'inspection:

Follow up

Report Date(s) /

Date(s) du Rapport : May 1, 2017

Licensee /

Titulaire de permis : HALDIMAND WAR MEMORIAL HOSPITAL
206 JOHN STREET, DUNNVILLE, ON, N1A-2P7

LTC Home /

Foyer de SLD : EDGEWATER GARDENS LONG TERM CARE
CENTRE
428 BROAD STREET WEST, DUNNVILLE, ON,
N1A-1T3

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : Greg Allen

To HALDIMAND WAR MEMORIAL HOSPITAL, you are hereby required to comply with the following order(s) by the date(s) set out below:



**Ministry of Health and
Long-Term Care**

Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007*, S.O. 2007, c.8

**Ministère de la Santé et
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section 154 of the *Long-Term Care
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Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
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Order # /

Ordre no : 001

Order Type /

Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order /

Lien vers ordre existant: 2016_341583_0022, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Order / Ordre :

The licensee shall ensure that staff are provided education in the following areas:

1. Provide training on minimizing of restraints to be provided to all direct care staff.
2. Provide training on the safe use of all equipment used for transferring and positioning to all PSW staff.

Grounds / Motifs :



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section 154 of the *Long-Term Care
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Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou
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de soins de longue durée, L.O. 2007, chap. 8*

1. In keeping with s.299 (1) of the Regulation, the Compliance Order is made based upon the application of the factors of severity of potential for actual harm/risk, scope of pattern, and ongoing non-compliance with Compliance Order in August 2014 and December 2016, related to minimizing of restraints.

A. The licensee failed to ensure that staff received annual training in all the areas required under subsection 76(7) of the Act in accordance with Ontario Regulation 79/10 s. 221(2)(1).

In December 2016, the home was issued a compliance order directing the home to ensure that all direct care staff received training related to minimizing of restraining in accordance with the Act and the regulations. Review of the home's "Staff Sign Off Sheet for Restraints Education", dated February 2017, and interview with the DOC confirmed that approximately 20 percent (%) of direct care staff had received training related to minimizing of restraining.

B. The licensee failed to ensure that the staff received training based on their assessed needs, in accordance with Ontario Regulation 79/10 s. 221(2)(2).

In December 2016, the home was issued a compliance order to ensure that all staff use safe transferring and positioning techniques when assisting residents. Specifically, the licensee was directed to educate all PSW staff on all equipment used for transferring and positioning, with a compliance date February 28, 2017.

Interview with the DOC revealed that as of April 20, 2017, the home had not ensured that any PSW staff were re-educated on safe use of equipment in the home, as required as part of the compliance order. (528) (528)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2017



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REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603



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When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.



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RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le titulaire de permis souhaite que le directeur examine;
- c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11^e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.



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En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 1st day of May, 2017

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : Cynthia DiTomasso

Service Area Office /

Bureau régional de services : Hamilton Service Area Office