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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l’inspection	Log # / No de registre	Type of Inspection / Genre d’inspection
Sep 25, 2019	2019_577611_0031	017045-19	Critical Incident System

Licensee/Titulaire de permis

Haldimand War Memorial Hospital
400 Broad Street West 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

KELLY CHUCKRY (611)

Inspection Summary/Résumé de l’inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 18, and 19, 2019

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, reviewed relevant clinical health records, relevant policies and procedures and the homes investigation notes.

The following Follow up inspection was completed concurrently with this inspection:
-2019-577611_0030_012399-19

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, registered staff, Personal Support Workers (PSWs), residents, and family members.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

1 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 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. 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. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident (CI) report was submitted to the Ministry of Long Term Care on an identified date, which reported that an incident occurred with resident #001, while care was being provided that resulted in an injury to this resident.

A review of the care plan, current at the time of the incident, identified that resident #001 required two staff to provide total assistance for care.

On an identified date, staff #101 was providing care to resident #001 without a second staff member to assist them. During this care, resident #001 sustained an injury that required additional assessment and intervention at another health care facility.

During an interview with staff #101, it was confirmed that they provided care to resident #101 without a second staff member. They further confirmed that they did not follow the plan of care for resident #001.

It was confirmed during an interview with the Administrator/Director of Care that staff #101 did not provide care to resident #001 as per the plan of care. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 25th day of September, 2019

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

Original report signed by the inspector.