Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Dec 20, 2019	2019_569508_0034	020489-19	Complaint

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

ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 5, 9, 10, 2019.

This inspection was conducted as an off-site inspection.

A complaint related to staffing shortages was inspected.

During the course of the inspection, the inspector reviewed relevant information in relation to staffing at the home.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC).

The following Inspection Protocols were used during this inspection:
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **2 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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there was an allowable exception to this requirement.

A complaint was reported to the Ministry of Long Term Care, regarding staffing shortages at the home. The complainant alleged that a Registered Nurse(RN) called in an absence for an eight (8) hour shift.

During interview with the Administrator/DOC, the following information was verified:

- over an identified period, there were a total of 12.5 hours where there was no RN in the building;
- the RN did call in an absence for an eight hour shift on the identified date;
- the RN on the evening shift stayed and covered a portion of the shift and a Registered Practical Nurse (RPN) came in early; however this resulted in no RN in the building for four and a half (4.5) hours;
- the RN called in an absence for the eight (8) hour shift on another identified date and could not be replaced. A RPN replaced this shift with a RN available by phone only resulting in no RN in the building for eight hours.

It was confirmed during interview with the Administrator/DOC, after review of the registered nursing schedules over an identified period of time, that on these identified dates and times, there was not at least one registered nurse on duty and present at all times. [s. 8. (3)]

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 there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there is an allowable exception to this requirment, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A complaint was submitted to the Ministry of Long Term Care regarding staffing shortages at the home. On an identified week end in 2019, the complainant alleged that due to a number of sick calls from Personal Support Workers (PSW)s, residents who were scheduled for their baths or showers did not receive them as they did not have enough staff.

During interview with the Administrator/DOC, it was confirmed that they did have a number of sick calls that could not be replaced over these identified dates and documentation reviewed over this weekend verified that residents scheduled for baths or showers did not receive them.

In addition, they were unable to offer the residents their missed baths on the days following as they could not get additional PSW staff to assist with the additional workload.

It was confirmed during interview with the Administrator/DOC that the home failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice. [s. 33.]

Issued on this 23rd day of December, 2019

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

Original report signed by the inspector.