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

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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
Apr 22, 2021	2021_555506_0011	018449-20, 021598-20	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

LESLEY EDWARDS (506)

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): April 14, 15 and 16, 2021.

The following intakes were completed:

Log #021598-20, Critical Incident System (CIS) #2963-000005-20 related to abuse and neglect and falls prevention; and,
Log #018449-20, CIS #2963-000004-20 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with The Administrator/Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), housekeeping staff, residents and Public Health Nurse.

During the course of the inspection, the inspector conducted a tour of the home, observed the provision of care, completed an infection prevention and control assessment (IPAC), reviewed resident health records, reviewed relevant policies and procedures and conducted interviews.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee has failed to ensure that the home was a safe environment related to maintaining infection prevention and control measures specified in "Chief Medical Officer of Health (CMOH) COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007 Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7," regarding dining and to ensure residents maintained physical distancing greater than 2 meters in order to reduce potential exposure and protect residents from COVID-19.

An observation of the two dining rooms in April 2021, confirmed that residents in the dining room were not greater than 2 meters apart with some tables having three and four residents seated together and no other safety measures had been put in place.

The Administrator/DOC confirmed that the home went back to pre COVID meal service approximately two weeks ago and did not consult with public health prior to doing this and were aware they were not following Directive #3 in regards to dining and ensuring that residents maintain physical distancing greater than 2 meters.

Not being physically distanced while in the dining room may increase residents risk of exposure to COVID-19.

Sources: CMOH COVID-19 Directive #3, observations of the dining room, interview with the Administrator/DOC.

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 home is a safe environment for residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident for which the resident was taken to hospital and that resulted in a significant change in the resident's health condition.

The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident for which the resident was taken to hospital and that resulted in a significant change in the resident's health condition.

A resident had an un-witnessed fall and was diagnosed with an injury.

Interview with the Administrator/DOC confirmed that the CIS report had not been submitted to the Director within the required time frame.

Sources: CIS, resident's clinical record and interview with Administrator/DOC. [s. 107. (3) 4.]

Issued on this 27th day of April, 2021

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

Original report signed by the inspector.