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
Jan 24, 2022	2022_968920_0001	011097-21	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

BARBARA GROHMANN (720920)

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): January 6-7, 10-12, 2022.

The following intake was completed in this complaint inspection:
Log # 011097-21, related to nutrition and personal care.

PLEASE NOTE: A Written Notification related to Long-Term Care Homes Act (LTCHA) chapter (c.) 8, section (s.) 6 (7), identified in a concurrent Critical Incident inspection (#2022-968920-0002) was issued in this report.

Lisa Vink (168) was present during this inspection and participated in the concurrent Critical Incident inspection #2022-968920-0002.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Director of Environmental Services/Nutrition, Infection Protection and Control (IPAC) Lead, Registered Nurses (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW), Dietary Aides (DA), Registered Dietitian (RD), Physiotherapy Assistant (PTA), Recreation Staff, Pandemic Workers, and residents.

During the course of the inspection, the inspector observed the provision of care and services, residents and their home areas, resident and staff interactions, and also reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Personal Support Services

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 O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under the nursing and personal support services program, as required in LTCHA s. 8 (1), including interventions, were documented for residents.

Point of Care (POC) bathing records were reviewed for a six-week period.

The records identified that:
i. a resident had eight of the required 12 baths documented,
ii. a second resident had 10 of the required 13 baths documented, and
iii. a third resident had eight of the required 12 baths documented.

A PSW acknowledged that when the staff were busy, they might not have completed all their charting, including bathing documentation. The PSW explained that the lack of documentation did not mean the residents did not get a bath.

Sources: Observations of resident; interviews with staff; POC bathing documents. [s. 30. (2)]

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 any actions taken with respect to a resident under the nursing and personal support services program, including interventions, are documented, to be implemented voluntarily.

WN #2: 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. (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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 has failed to ensure that the written plan of care for a resident set out the planned care for the resident regarding nail care.

A resident was seen to have a rough nail on their finger. The next day, the resident had additional rough nails. The current written plan of care did not include specific directions regarding nail care for the resident.

The Administrator/DOC explained that it was the home's practice to perform nail care on bath days. The resident’s bath days were scheduled for twice a week and POC bathing documentation indicated that nail care was performed.

The Administrator/DOC agreed that rough nails were an ongoing concern and specific direction regarding nail care should be included in the resident’s written plan of care.

Failure to ensure that the plan of care included the planned care for the resident had the potential to increase the risk of unkempt nails.

Sources: Resident observations and interview, interviews with Administrator/DOC and other staff; written plan of care and bath documentation. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the dietary intervention set out in a resident’s written plan of care was provided.

The RD set out nutrition interventions in a resident’s written plan of care. An annual

nutrition assessment was completed by the RD where all interventions were deemed effective at weight maintenance.

The master servery report indicated the interventions in the resident's diet notes.

During breakfast tray service the resident did not received one of the interventions. The dietary aide explained that the resident no longer received that specific intervention. The RD confirmed that the resident should receive care as per the plan of care and that their assessment was based on all interventions being provided.

By not receiving the prescribed intervention, the resident was at minimal risk of not meeting their nutritional needs.

Sources: Observation of tray platting; interviews with RD and other staff; master servery report, therapeutic spreadsheet Fall/Winter 2021/22 and resident's written plan of care. [s. 6. (7)]

3. 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.

A resident had a device that was to be changed on a routine basis.

The electronic medical record identified the date when the device was last changed and the date it was scheduled to be changed. There was no documentation to support that the device was changed as scheduled.

A few weeks later, the resident presented with behavioual changes. The device was changed, and they received a treatment due to their behavioural changes. The RN who was scheduled to change the device failed to do so as an oversight.

Failure to provide the care as set out in the plan of care put the resident at risk for discomfort.

Sources: A review of the resident's physician's orders, progress notes and medical records, and interviews with staff. [s. 6. (7)]

Issued on this 28th day of January, 2022

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

Original report signed by the inspector.