Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: March 6, 2023	
Inspection Number: 2023-1446-0002	
Inspection Type: Follow up Critical Incident System	
Licensee: Haldimand War Memorial Hospital	
Long Term Care Home and City: Edgewater Gardens Long Term Care Centre, Dunnville	
Lead Inspector Emma Volpatti (740883)	**Inspector Digital Signature** Emma Volpatti Digitally signed by Emma Volpatti Date: 2023.03.09 09:33:29 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 13-15, 17 and 21, 2023

The following intake(s) were inspected:

- Intake: #00004118 [CI: 2963-000002-22] related to the prevention of abuse and neglect.
- Intake: #00006448 [CI: 2963-000005-22] related to falls prevention and management.
- Intake: #00015010 [Follow-up] related to Duty to Protect.
- Intake: #00015011 [Follow-up] related to Nutritional Care and Hydration Programs.
- Intake: #00019053 [CI: 2963-000001-23] related to falls prevention and management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
FLTCA, 2021	s. 24 (1)	2022-1446-0001	001	Emma Volpatti (#740883)
O. Reg. 246/22	s. 74 (2) (c)	2022-1446-0001	002	Emma Volpatti (#740883)

The following **Inspection Protocols** were used during this inspection:

Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that a residents plan of care was reviewed and revised when the resident's care needs changed related to fall prevention interventions.

Rationale and Summary

On an identified date, a resident was observed to have an intervention in place. Review of the resident's clinical record showed that the plan of care did not include this intervention. The Director of Care (DOC) confirmed that the plan of care should have been revised when the intervention was implemented.

On an identified date, the residents plan of care was revised to reflect that the care needs had changed.

Sources: observations of the resident, interview with the DOC, the residents plan of care.
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Date Remedy Implemented: February 17, 2023

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 50 (2) (b) (i)

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 50 (2) (b) (i) of O. Reg 79/10. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 55 (2) (b) (i) of O.Reg. 246/22 under the FLTCA, 2021.

A) The licensee has failed to ensure that a resident's skin impairment was assessed by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Rationale and Summary

On an identified date, a resident was noted to have a skin impairment. A Registered Practical Nurse (RPN) documented the skin impairment in the resident's clinical record in a progress note.

The Long-Term Care Home's (LTCH) wound manual outlined the steps to be taken when a skin impairment is identified. One of these steps included a skin assessment using the Wound Assessment Tool located on the home's Electronic Medical System (EMS).

A review of the resident's clinical record showed there was no Wound Assessment Tool done for the identified skin impairment. The RPN confirmed that they did not complete a skin assessment for the skin impairment.

The DOC verified that the Wound Assessment Tool was the appropriate assessment instrument to be used for skin and wound impairments, and acknowledged that it was not completed.

Sources: The resident's clinical record, interview with the DOC and other staff, the home's policy titled Skin and Wound Program, last updated January 2017.
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B) The licensee has failed to ensure that a resident's skin impairment was assessed by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Rationale and Summary

On an identified date, a resident had a significant change in condition and as a result, had an identified skin impairment.

A review of the resident's clinical records indicated that a Registered Nurse (RN) completed a progress note describing the skin impairment, but no Wound Assessment Tool was done. The DOC acknowledged that this had not been completed.

Sources: the resident's clinical records, interview with the DOC, the home's policy titled Skin and Wound Program, last updated January 2017.
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C) The licensee has failed to ensure that the resident's skin impairment was assessed by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Rationale and Summary

On an identified date, an RPN documented under a progress note that a resident experienced a change in condition and when they were assessed, it was noted they had a skin impairment.

A review of the resident's clinical record showed there was no Wound Assessment Tool done for the identified skin impairment. The RPN confirmed that they did not complete a skin assessment using the Wound Assessment Tool when the skin impairment was identified.

Failing to complete a skin assessment using a clinically appropriate tool put residents at risk of potential worsening skin conditions.

Sources: the resident's clinical record, interview with an RPN, the home's policy titled Skin and Wound Program, last updated January 2017.
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WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 24 (1) 2.

The licensee has failed to ensure that a suspicion of abuse by a visitor to a resident was reported immediately to the Director.

Rationale and Summary

A Critical Incident (CI) report was submitted to the Director on an identified date, reporting a suspicion of physical abuse by a visitor to a resident.

A review of the resident's clinical record indicated that on an identified date, the resident was observed to have two skin impairments following a visit by a family member. The RPN confirmed that they immediately reported the incident to the DOC.

The DOC acknowledged that they were made aware of the incident on the day it occurred, but did not report it to the Director until two days later.

Sources: Interviews with the DOC and RPN, the resident's clinical record, CI report.
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WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

Rationale and Summary

On an identified date, a resident was found lying on their fall mat next to their bed. Upon assessment, an RPN noted the resident had significant pain and a skin impairment. The staff then lowered the resident's bed and used the mat to lift and slide the resident back into their bed.

The home's policy titled Lifting and Transferring Residents indicated that when a resident is found on the floor, a mechanical lift shall be used to pick up the resident.

The DOC acknowledged that the transfer was unsafe as it did not follow the home's policy of using

mechanical lifts for every resident who falls.

Failing to use safe transferring techniques had the potential to result in further injury to the resident.

Sources: interview with DOC and RPN, the resident's clinical record, the homes policy titled Lifting and Transferring Residents, dated July 2018.
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