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

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Original Public Report

Report Issue Date: March 12, 2024	
Inspection Number: 2024-1446-0001	
Inspection Type: Proactive Compliance Inspection	
Licensee: Haldimand War Memorial Hospital	
Long Term Care Home and City: Edgewater Gardens Long Term Care Centre, Dunnville	
Lead Inspector Olive Nenzeko (C205)	**Inspector Digital Signature** Olive Mameza Nenzeko Digitally signed by Olive Mameza Nenzeko Date: 2024.03.27 14:50:55 -04'00'
Additional Inspector(s) Betty-Jean Hendricken (740884)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 22, 23, 26-29, 2024 and March 1, 4, 5, 2024.

The following intake(s) were inspected:
- Intake: #00109171 related to Proactive Compliance Inspection (PCI).

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration

Medication Management
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
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)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act included the current version of the visitor policy made under section 267

Rationale and Summary
During the initial tour of the Long-Term Care Home (LTCH), LTCH Inspector #C205 could not locate the home's visitor policy.

The Administrator confirmed that their visitor policy was not posted in the home and immediately printed and posted a new one.

Sources : Initial tour of the home, interview with Administrator.
[C205]

Date Remedy Implemented: February 22, 2024.

WRITTEN NOTIFICATION: Dealing with complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (d)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(d) the final resolution, if any;

The licensee has failed to ensure that a documented record was kept in the home that included the final resolution to a resident's verbal/written complaint.

Rationale and Summary
During an interview, a resident told LTCH Inspector #C205 that their food was often cold and overcooked, and that despite reporting their concern, the LTCH did nothing about it.

There was a progress note regarding the resident's complaint about cold food, and an email was sent to dietary staff about it.

A review of the 2023 complaint 's binder did not include the final resolution to the verbal/written complaint.

The Nutrition and Environmental Supervisor (NES) indicated that they followed up with the resident on their concern, and that there was no documented record of the resident's complaint and actions taken as it should have been.

Sources: 2023 complaint binder; email complaint; progress notes; interview with resident and NES.
[C205]

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

A. 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 related to physiotherapy treatment.

Rationale and Summary
A resident's plan of care identified that they had physiotherapy two to three times per week.

During an interview, the resident reported that they had not received physiotherapy

for approximately three weeks.

The resident's Physiotherapy Treatment Record (PTR) showed that they had not had physiotherapy treatment as required for about three weeks, which was also confirmed by the Physiotherapist Assistant (PTA).

Sources : Resident's PTR; interview with resident and PTA.
[C205]

B. 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 related to hydration.

Rationale and Summary
A resident's plan of care stated that residents who fall below the minimal fluid requirement for three days will be assessed for dehydration and fluid imbalance, and a referral will be sent to the dietitian for follow-up.

A review of the resident fluid intake revealed that they did not meet their daily fluid goal for several days. The resident was assessed for dehydration during these days, however a referral was not sent to the dietician until a later time.

The Nutrition and Environmental Supervisor (NES) admitted that a referral should have been completed for the resident when they did not meet their daily fluid goal for three days.

Failure to ensure the resident 's plan of care was provided to the resident as specified in their plan related to hydration and physiotherapy prevented the resident from receiving the care they needed for their well-being.

Sources: Resident 's clinical records, Interview with NES.
[C205]

WRITTEN NOTIFICATION: General Requirement for Programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A. The licensee has failed to evaluate the Pain Management Program at least annually, as required.

Rationale and Summary
A program evaluation was not completed for the Pain Management Program in 2023.

Record review showed that the last Pain Management Program Evaluation was completed in 2017.

In an interview and in email correspondence, the home's Administrator confirmed that a Program Evaluation for the Pain Management Program was not completed annually as required.

Sources: Interview with Administrator; Pain Management Program Evaluation dated 2017; email from Administrator
[740884]

B. The licensee has failed to evaluate the Falls Prevention and Management Program at least annually, as required.

Rationale and Summary
A program evaluation was not completed for the Falls Prevention and Management Program in 2023.

Record review showed that the last Falls Prevention and Management Program Evaluation was completed in 2017.

In an interview and in email correspondence, the home's Administrator confirmed that a Program Evaluation for the Falls Prevention and Management Program was not completed annually as required.

Sources: Interview with Administrator, Pain Management Program Evaluation dated 2017, email from Administrator
[740884]

C. The licensee has failed to evaluate the Skin and Wound Care Program at least annually, as required.

Rationale and Summary
A program evaluation was not completed for the Skin and Wound Care Program in 2023.

Record review showed that the last Skin and Wound Care Program Evaluation was completed in 2017.
In an interview and in email correspondence, the home's Administrator confirmed that a Program Evaluation for the Skin and Wound Care Program was not completed annually as required.

Sources: Interview with Administrator, Skin and Wound Care Program Evaluation dated 2017, email from Administrator..
[740884]

WRITTEN NOTIFICATION: Infection prevention and control program (IPAC)

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2022, was implemented.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that Additional Precautions were to be followed in the IPAC program which included (f) the appropriate selection, application, removal, and disposal of Personal Protective Equipment (PPE).

LTCH Inspector #C205 observed a contact precaution signage on a resident 's door. Inspector #C205 observed a staff assisting the resident in their room while wearing no gown.

The LTCH Personal Protective Equipment (PPE)'s policy stated that required PPE for contact precautions included gloves and gown. The policy also stated that contact precautions were required for organisms spread via direct and indirect contact, with indirect contact defined as a susceptible person touching a surface that has been contaminated by an infected person, rather than the person themselves.

Failure to follow IPAC routine practices and additional precautions increased the risk of transmission of infection in the home.

Sources : Observation; PPE Policy (created July 2022).
[C205]

WRITTEN NOTIFICATION: Dealing with complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (c)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

The licensee has failed to ensure that a documented record was kept in the home that included the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required.

Rationale and Summary
During an interview, a resident told LTCH Inspector #C205 that their food was often cold and overcooked, and that despite reporting their concern, the LTCH did nothing about it.

On an identified date, there was a progress note regarding the resident's complaint about cold food, and an email was sent to dietary staff about it.

A review of the 2023 complaint 's binder did not include the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required.

The Nutrition and Environmental Supervisor (NES) indicated that they followed up with the resident on their concern, and that there was no documented record of the resident's complaint and actions taken as it should have been.

Sources: 2023 complaint binder; email complaint; progress notes; interview with resident and NES.
[C205]

WRITTEN NOTIFICATION: Dealing with complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (e)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(e) every date on which any response was provided to the complainant and a description of the response; and

The licensee has failed to ensure that a documented record was kept in the home that included every date on which any response was provided to a resident regarding their verbal/written complaint and a description of the response.

Rationale and Summary
During an interview, a resident told LTCH Inspector #C205 that their food was often cold and overcooked, and that despite reporting their concern, the LTCH did nothing about it.

on a specific date, there was a progress note regarding the resident's complaint about cold food, and an email was sent to dietary staff about it.

A review of the 2023 complaint 's binder did not include every date on which any response was provided to the resident regarding their verbal/written complaint and a description of the response, which was also verified by NES.

Sources: 2023 complaint binder; email complaint; progress notes; interview with resident and NES.
[C205]

WRITTEN NOTIFICATION: Dealing with complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (f)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(f) any response made in turn by the complainant.

The licensee has failed to ensure that a documented record was kept in the home

that included any response made in turn by a resident regarding their verbal/written complaint.

Rationale and Summary
During an interview, a resident told LTCH Inspector #C205 that their food was often cold and overcooked, and that despite reporting their concern, the LTCH did nothing about it.

On an identified date, there was a progress note regarding the resident's complaint about cold food, and an email was sent to dietary staff about it.

A review of the 2023 complaint ‘s binder did not include any response made by the resident regarding their verbal/written complaint about cold food.

NES acknowledged that they followed up with the resident on their concern, and that there was no documented record of the resident's complaint and actions taken and resident 's response as it should have been.

Sources: 2023 complaint binder; email complaint; progress notes; interview with resident and NES.
[C205]

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (1)
Continuous quality improvement initiative report
s. 168 (1) Every licensee of a long-term care home shall prepare a report on the continuous quality improvement initiative for the home for each fiscal year no later

than three months after the end of the fiscal year and, subject to section 271, shall publish a copy of each report on its website.

The licensee has failed to prepare a report on the Continuous Quality Improvement Initiative for the home for the year 2022, as required.

Rationale and Summary
The Continuous Quality Improvement (CQI) Lead confirmed that the home did not complete a Continuous Quality Improvement Initiative report for the year 2022, as required.

Sources: Interview with CQI Lead, review of the home's website.
[740884]

WRITTEN NOTIFICATION: Orientation

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (e)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(e) what to do if experiencing symptoms of infectious disease;

The licensee has failed to ensure that the training for staff in infection prevention and control included what to do if experiencing symptoms of infectious disease.

Rationale and Summary
A review of two staff's training record related to IPAC did not include what to do if experiencing symptoms of infectious disease.

The Administrator and the Director of Care (DOC) admitted that their IPAC training for staff on Surge Learning did not cover what to do if experiencing symptoms of infectious disease.

Failure to include this topic in their IPAC training, staff may have been unclear of what to do when residents exhibited symptoms of infectious disease.

Sources: Staff's training record; interview with Administrator and DOC.
[C205]

WRITTEN NOTIFICATION: Orientation

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (f)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(f) cleaning and disinfection practices;

The licensee has failed to ensure that the training for staff in infection prevention and control included cleaning and disinfection practices.

Rationale and Summary
A review of two staff's training record related to IPAC did not cover cleaning and disinfection practices.

The Administrator and the Director of Care (DOC) admitted that their IPAC training for staff on Surge Learning did not include cleaning and disinfection practices.

Failure to include this topic in their IPAC training, staff may have been unclear of

cleaning and disinfection practices.

Sources: Staff's training record; interview with Administrator and DOC.
[C205]

WRITTEN NOTIFICATION: Orientation

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (h)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(h) handling and disposing of biological and clinical waste including used personal protective equipment.

The licensee has failed to ensure that the training for staff in infection prevention and control included handling and disposing of biological and clinical waste including used personal protective equipment.

Rationale and Summary
A review of two staff's training record related to IPAC did not include handling and disposing of biological and clinical waste including used personal protective equipment.

The Administrator and the Director of Care (DOC) verified that their IPAC training for staff on Surge Learning did not include handling and disposing of biological and clinical waste including used personal protective equipment (PPE).

Failing to include this topic in their IPAC training, staff may have been unaware of how to handle and dispose biological and clinical waste including used PPE.

Sources: Staff training record; interview with Administrator and DOC [C205]