Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 28, 2016	2016_323130_0009	013732-16	Resident Quality Inspection

Licensee/Titulaire de permis

MIRDEM NURSING HOMES LTD
176 VICTORIA AVENUE NORTH HAMILTON ON L8L 5G1

Long-Term Care Home/Foyer de soins de longue durée

VICTORIA GARDENS LONG TERM CARE
176 VICTORIA AVENUE NORTH HAMILTON ON L8L 5G1

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

GILLIAN TRACEY (130), ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): May 9, 10, 11, 12, 13, 16, 2016.

PLEASE NOTE: The following onsite inquiries were conducted currently with this RQI: 010190-15, 010242-15, 022217-15 and 002118-16 related to falls prevention, 029914-15 related to amending critical incidents (CI's), 036308-15 and 010861-16 related to responsive behaviours and 004850-16 related to prevention of abuse.

The following complaint inspection was conducted currently with this RQI: 036189-15 related to responsive behaviours and furnishings.

The following critical incident system (CIS) inspections were conducted currently with this RQI: 003731-15 and 026947-15 related to responsive behaviours and 032547-15 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), registered staff, includung Registered Nurses (RNs) and Registered Practical Nurses (RPNs), personal support workers (PSWs), Resident Assessment Instrument (RAI) Coordinator, President of Residents' Council, President/Delegate of Family Council, residents and families.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **5 WN(s)**
- **3 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	Legendé 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. 6. Plan of care

Specifically failed to comply with the following:

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 failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) The plan of care for resident #202, identified the resident was at risk for falls and required the minimum assistance of two staff for all transfers. On an identified date in November 2015, staff #501 was helping the resident who was on the toilet. The resident stated they were confident to stand so that staff #501 could pull up their incontinent product. The staff directed the resident to hold onto the grab bar. The resident stood up, and within in a few seconds their legs lost strength and caused them to fall. The resident sustained an injury which required treatment, as a result of the fall.

The DOC confirmed that staff #501, did not seek help from a second staff before transferring the resident and that care was not provided as specified in the plan, specifically related to transfers. (Inspector #130).

PLEASE NOTE: This non compliance was issued as a result of the following critical incident inspection : #032547-15, which was conducted simultaneously with the RQI. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in accordance with manufacturer's instructions.

It was observed on May 9, 2016, in the second floor tub room, that the chair lift that staff used to bathe residents did not have the required lap belt to secure residents. According to the manufacturer's instructions, residents were to be secured using the lap belt while in the chair lift to prevent residents from falling or slipping out of the chair.

It was confirmed by the DOC on May 9, 2016, that staff were not using the chair lift in accordance with the manufacturer's instructions. (Inspector #508) [s. 23.]

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 staff use all equipment, supplies, devices, assistive aids and positioning aids in accordance with manufacturer's instructions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

During a tour of the home on May 9, 2016, it was observed in the second floor tub room that a cabinet secured to the wall which contained the residents' nail clippers, nail sticks and combs had uncovered toothbrushes in six of the drawers. The drawers were pulled open and it was observed that some of the drawers contained nail clippings and the toothbrush bristles were placed on top of the used nail clippers and combs.

During an interview with the DOC on May 9, 2016, the DOC confirmed that the toothbrushes should not have been put into the drawers with the bristles touching the residents' nail clippers and combs.

On May 11, 2016, at 1244 hours, the Inspector observed a basket containing a partial cigarette, toothbrush and several soiled disposable razors, in the cupboard of a shared washroom. The staff confirmed these items were not hygienically stored. (Inspector #130).

It was confirmed by the DOC that the staff did not participate in the implementation of the infection prevention and control program. [s. 229. (4)]

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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #4: 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 :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

A) On May 10, 2016, at 1130 hours, a maintenance cart was observed in the service corridor, on the first floor, which was accessible to residents. The cart was unsupervised and contained various tools, including a power drill, scissors and chemicals such as WD40 and rubbing alcohol.

A storage room door located in the same service corridor was observed to be ajar, in the room there were various bottles labelled "toxic" and some unlabelled bottles containing unidentified liquids.

The DOC confirmed at 1140 hours, that the maintenance cart should be locked in the storage room when not in use and that the storage room door should be locked at all times to ensure a safe and secure environment for residents. (Inspector #130). [s. 5.]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A) In March 2015, resident #203 initiated a physical altercation with co-resident #204, which resulted in resident #204's fall to the floor and consequent injury. Resident #203 had known responsive behaviours. The DOC confirmed that resident #204 was not protected from abuse by resident #203. (Inspector #130).

PLEASE NOTE: This non compliance was identified as a result of the following onsite Critical Incident Inspection: 003731-15, which was conducted simultaneously with the RQI. [s. 19. (1)]

Issued on this 28th day of June, 2016

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

Original report signed by the inspector.