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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 25, 2019	2019_587129_0001	007536-18	Complaint

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

PHYLLIS HILTZ-BONTJE (129)

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 21, 22, 23, 2019.

The following Complaint intake was inspected:
007536-18- related to potential safety risk for a resident

During the course of the inspection, the inspector(s) spoke with Personal Support Workers, Activity Aide, the Director of Care and the Administrator.

During the course of the inspection the Inspector made observations of the resident, reviewed clinical records, reviewed records provided by the complainant as well as other records maintained by the home.

The following Inspection Protocols were used during this inspection:
Admission and Discharge

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. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure the plan of care was based on, at a minimum, an interdisciplinary assessment of safety risks.

Following resident #001's admission to the home on an identified date, the clinical record identified that the resident's safety was at risk during an identified activity, when the following was documented by staff:

a) Four days after resident #001 was admitted to the home, they engaged in the identified activity. The home was subsequently contacted by a third party to assist the resident to return to the home.

b) A day following the above noted incident, staff #103 completed an initial activation assessment and indicated the resident was at risk related to the identified activity.

c) Three days following the above noted documentation, resident #001 engaged in the identified activity. The home was subsequently contacted by a third party to assist the resident to return to the home.

d) Information available to staff in the home when the resident was admitted indicated there had been previous concerns about the resident engaging in the identified activity and making unsafe decision during the identified activity.

During an interview with the DOC on an identified date, they confirmed that the risk to the resident's safety while engaging in the identified activity had not been assessed and a plan of care had not been developed after the first incident, after staff #103 indicated the resident was at risk or after the second incident noted above.

Resident #001 demonstrated they were at risk when the engaged in the identified activity and the resident's plan of care was not based on an assessment of this risk. [s. 26. (3) 19.]

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 and ensuring the plan of care is based on, at a minimum, an interdisciplinary assessment of safety risks., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.

Victoria Gardens has a license capacity of 76 long-term care beds.

Registered Nurse (RN) #102 who was not an employee of the licensee and a member of the regular nursing staff was the only RN in the building during a specific shift on an identified date.

During an interview on an identified date, the Director of Care (DOC) confirmed that one RN is scheduled to work on each day, evening and night shift, that RN #102 was the only RN in the building on the identified date, RN #102 was an employee of an employment agency and the scheduling of RN #102 was not a result of an emergency. [s. 8. (3)]

Issued on this 4th day of February, 2019

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

Original report signed by the inspector.