Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Jul 25, 2019	2019_573581_0009	006214-19	Critical Incident System

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

DIANNE BARSEVICH (581)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 15, 16 and 17, 2019.

The following Critical Incident Intakes were inspected:
0006214-19- related to a fall with injury.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Practical Nurses (RPN), Physiotherapist (PT), Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector observed the provision of care, reviewed relevant clinical health documentation and hospital records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A review of Critical Incident System log #006214-19 submitted on an identified date in March 2019, identified resident #001 had an unwitnessed fall and sustained an injury. A device was put in place to manage the diagnosis.

A review of the plan of care identified resident #001 was to be transferred to the toilet with an identified level of assistance.

Review of the Physiotherapist (PT) progress note dated on an identified date in May 2019, indicated specific direction related to the application of the device.

On an identified date in July 2019, resident #001 was observed sitting in the wheelchair with the specific device not in place.

Resident #001 was observed on an identified date in July 2019, being transferred by PSW #103, #104 and #105 from the wheelchair to the toilet and a specific device was applied; however, not as the plan of care directed. After the resident was transferred back to wheelchair, PSW staff removed the device.

During an interview with PSW #104 and #105 after the transfer, they confirmed they did not transfer the resident according to the plan of care. They stated the device was removed at specific times.

In an interview with the PT they indicated the device was to be applied and the resident was to be transferred a specific way related to their injury. The PT said they provided education to PSW and registered staff on how and when the device was to be applied.

The PSW staff failed to use safe transferring and positioning devices or techniques when assisting resident #001. [s. 36.]

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 safe transferring and positioning devices or techniques when assisting residents, 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 there was a written plan of care for each resident that sets out the planned care for the resident.

According to the progress note dated in March 2019, resident #001 had an unwitnessed fall and sustained an injury.

On an identified dated in July 2019, resident #001 was observed in bed with a specific falls intervention in place.

Review of the written plan of care identified interventions that were in place to manage the resident's falls.

During an interview with PSW #110 they stated the resident had a specific falls intervention in place since they fell and sustained an injury.

Following a review of the current written plan of care with the Director of Care (DOC) on an identified date in July 2019, they confirmed the specific intervention was planned care for the resident as an intervention to manage their falls and should have been documented in the written plan of care.

The written plan of care did not set out the planned care for resident #001. [s. 6. (1) (a)]

2. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A review of Critical Incident System log #006214-19 submitted on an identified date in March 2019, identified resident #001 had an unwitnessed fall and sustained an injury. A specific device was put in place.

Review of the consultation clinic note on an identified date in May 2019, identified the physician recommended specific care related to the injury for a specified period of time.

A review of the clinical record identified the Physiotherapist (PT) documented in the written plan of care on an identified day in May 2019, that the resident was to receive specific care; however, was not based on the assessment by the physician.

Following a review of the clinic note from the physician with the Physiotherapist, they confirmed the resident was to receive specific care with physiotherapy staff and the assessment from the physician should have been followed.

The care set out in the plan of care was not based on an assessment of the resident and the needs and preferences of that resident. [s. 6. (2)]

3. 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 review of the clinical record identified that resident #001 fell on an identified date in

March 2019 and sustained an injury.

A review of the current plan of care identified under the transfer focus that resident #001 required assistance with transfers using a specific device which was applied at specific times.

On an identified date in July 2019, resident #001 was observed being transferred from the wheelchair to the toilet by PSW #103, #104 and #105. PSW #105 applied the specific device incorrectly; however, acknowledged they had not received training on the application of the device.

In an interview with the PT on an identified date in July 2019, they stated the device was to be applied over a specific location after the resident sustained an injury.

Care was not provided as specified in the plan. [s. 6. (7)]

Issued on this 25th day of July, 2019

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

Original report signed by the inspector.