Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux 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
Sep 20, 2021	2021_916168_0005	025826-20, 002289-21, 006895-21, 012085-21, 014486-21	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

LISA VINK (168), JENNIFER ALLEN (706480)

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): September 10, 13, 14, 15 and 17, 2021.

During this Critical Incident System Inspection, the following intakes were inspected:
Log 025826-20 related to plan of care;
Log 002289-21 related to the prevention of abuse and neglect;
Log 006895-21 related to the prevention of abuse and neglect and responsive behaviours;
Log 012085-21 related to falls prevention and management; and
Log 014486-21 related to the prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), housekeepers, sanitizers, screeners, a wheelchair vendor, Social Worker, Behavioural Support Ontario (BSO) staff and residents.

During the course of this inspection, the inspectors observed the provision of care and services, reviewed relevant records, including but not limited to, clinical health records, investigative notes, policies and procedures, a Human Resource file and program evaluations.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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

4 WN(s)
2 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any procedure, that the procedure was complied with.

In accordance with Ontario Regulation 79/10 s. 48 (1) 1 and in reference to O. Reg s.30 (1) 1, the licensee was to ensure that in respect of the organized falls prevention and management program there was a written description of the program that included relevant procedures and that the procedures were complied with.

Specifically, staff did not comply with the home's procedure for Head Injury Routine, which identified that a resident's vital signs were to be taken immediately following an incident, and then every 15 minutes for 45 minutes; if stable every hour for three hours; if stable every four hours twice and then once a day for seven days.
There was no direction that the assessment was not required to be completed if the resident was sleeping or eating.

i. Resident #013 sustained a fall which resulted in injuries.
Staff initiated a head injury routine on the Neurological Vital Signs Record and recorded vital signs initially and then every 30 minutes on three occasions followed by every hour on two occasions.
An assessment scheduled for the middle of the night was not recorded and the record noted "sleeping".
Assessments resumed again as required according to the procedure until a new

assessment was initiated.
Staff did not follow the home's procedure for Head Injury Routine when they failed to assess the resident at the frequency as outlined in the procedure including every 15 minutes for the first 45 minutes and did not assess the resident when they were sleeping.

During the course of the inspection the Neurological Vital Signs Record was revised to ensure that it was consistent with the directions on the Head Injury Routine and staff were reinstructed regarding the expectations of the procedure.

Sources: A review of the progress notes and assessments of resident #013, a review of the procedure Head Injury Routine and interviews with staff. (168)

ii. Resident #014 sustained an unwitnessed fall and a Neurological Vital Signs assessment record was initiated.
Assessments were completed initially and then every 30 minutes on two occasions.
Assessments were not completed on three occasions during the night and the record noted "sleeping", additionally the record was blank for a scheduled assessment in the morning. Assessments resumed again as required according to the procedure until a new assessment was initiated.

Staff did not follow the home's procedure for Head Injury Routine when they failed to assess the resident at the frequency as outlined in the procedure including every 15 minutes for the first 45 minutes and did not assess the resident when they were sleeping.

Sources: A review of the progress notes and assessments of resident #014, a review of the procedure Head Injury Routine and interviews with staff. (706480)

iii. Resident #015 had an unwitnessed fall and a Neurological Vital Signs assessment record was initiated immediately.
Assessments were not recorded during a meal and the record noted "eating".
Assessments resumed again following the meal; however, were not recorded on two occasions during the night and the record noted "sleeping".
Assessments resumed again as required according to the procedure and continued for the next seven days as required.

Staff did not follow the home's procedure for Head Injury Routine when they failed to assess the resident at the frequency as outlined in the procedure including every 15 minutes for the first 45 minutes and did not assess the resident when they were sleeping

and eating.

Sources: A review of the progress notes and assessments of resident #015, a review of the procedure Head Injury Routine and interviews with staff. [s. 8. (1) (b)]

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 where the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any procedure, that the procedure is complied with, to be implemented voluntarily.

WN #2: 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.

Ontario Regulation 79/10, section 2 (1) defined abuse.

i. Resident #013 and #012 were observed in an area and a PSW observed an incident between the two residents which resulted in an injury to resident #013.
Staff immediately responded to the incident, resident #013 was assessed and treatment was provided.
Resident #013 was not able to recall what happened immediately following the incident.
Resident #012 initially did not respond when questioned regarding the incident and on subsequent questioning denied their involvement in the incident.
The police were notified of the incident.

The plans of care for both residents in place prior to the incident noted that they had the potential for responsive behaviours and included interventions in an effort to manage the identified behaviours.

Resident #013 was not protected from abuse by resident #012.

Sources: Record review of residents #012 and #013, review of investigative notes, and interviews with residents #012 and #013 and staff.

ii. A resident was involved in an incident involving a staff member.
Staff documented in the progress notes that the resident presented with responsive behaviours on the identified shift.
The following day the resident reported that they sustained an injury from the interaction.
A review of camera footage for the shift showed, in part, the interaction. The staff member did not stop an activity when the resident's actions suggested resistance.
Based on the video footage the staff ignored the actions of the resident and did not acknowledge their efforts to resist the care.
Staff and resident interviews regarding the interaction were not consistent.
Interview with the staff confirmed that they continued with the activity despite the actions, which suggested resistance, of the resident.

The resident was not protected from abuse by staff.

Sources: Record review of a resident, review of investigative notes, video footage, and interviews with the resident and staff. [s. 19. (1)]

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 residents are protected from abuse, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 21. Every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints. 2007, c. 8, s. 21.

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

The home's policy Resident Abuse identified that staff were to immediately report any suspected or actual concerns of abuse, in a written form, including the type of abuse being reported.
An interview confirmed the expectation, of a written report, included allegations of abuse.

A resident demonstrated responsive behaviours and was involved in an incident involving a staff member.
The following day the resident voiced concerns regarding the incident, an allegation of abuse.
The staff disclosed during an interview that the resident accused them of abuse, although the staff member denied the allegation.
Interview with a second staff member, who worked on the identified shift, confirmed that the resident accused the staff; however, identified that they did not witness the alleged activity.
A review of the documentation regarding the incident noted that the resident displayed responsive behaviours; however, there was no documentation of an allegation of abuse.
The staff did not make a written record of the allegation of abuse.
There was no written record of the report of abuse, or the type of abuse, until the following day as recorded by a different staff member.

Sources: Review of Resident Abuse policy, review of records related to a resident and investigative notes and interview with staff. [s. 21.]

WN #4: 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. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee failed to ensure a hand hygiene program was in place in accordance with the Ontario evidenced based hand hygiene program "Just Clean Your Hands" related to staff to assist residents with hand hygiene before and after snacks.

On two occasions, on two different floors, nourishment pass was observed.
Staff did not provide a number of residents with assistance with hand hygiene immediately prior to distribution of the nourishment.
Staff confirmed that they provided residents hand hygiene assistance prior to and following meals, but that they had not provided hand hygiene prior to the distribution of the nourishment.
The home did not have a written program in place for resident hand hygiene specifically at nourishment times.
The Just Clean Your Hands program required that staff assisted residents to clean their hands before and after snacks.

Failure to have a hand hygiene program in place in accordance with evidenced based practices presented a minimal risk to residents related to the possible ingestion of disease causing organisms that may have been on their hands.

Sources: Observations of residents at nourishment time, review of the COVID-19 Pandemic Plan and the “Just Clean Your Hands” program resources, and interviews with staff. [s. 229. (9)]

Issued on this 20th day of September, 2021

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

Original report signed by the inspector.