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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 20, 2021	2021_848748_0016	017289-21, 018518-21	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

EMMY HARTMANN (748)

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): December 6, 7, 8, and 9, 2021.

The following intakes were completed during this Complaint Inspection:

Log #017289-21, was related to admissions and discharge.
Log #018518-21, was related to resident care, and an allegation of abuse.

During the course of the inspection, the inspector(s) spoke with residents, the Administrator, Director of Care (DOC), Administrator in-training, Receptionist, Infection Control Nurse, Director of Activation, Maintenance, Laundry Aides, Housekeepers, registered nurses (RN), registered practical nurses (RPN), and personal support workers (PSW).

During the course of the inspection, the inspector also observed resident and staff interactions, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Admission and Discharge
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 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. 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 all staff participated in the implementation of the Infection Prevention and Control (IPAC) Program.

1. The Ministry of Health and Long Term Care (MOHLTC) Control of Respiratory Infection Outbreaks in Long Term Care Homes, November 2018, document stated that notices shall be placed on the door of ill residents or in other visible locations advising all visitors to check at the nursing station before entering the room.

The home's policy identified that a resident on additional precautions would have signage indicating the type of IPAC precautions, posted on the outside of their room.

During an observation of care, an identified room was observed to have a Personal Protective Equipment (PPE) cart set up outside of the room and a door caddy containing more PPE hung on the door. There was no signage indicating that the residents were on additional precautions.

The RPN on duty identified that the residents were under droplet and contact precautions. They acknowledged that there was no signage, and that there should have been signage placed at the door.

Sources: Observation of care; the home's COVID-19 Pandemic Plan, last reviewed September 14, 2021; and interview with RPN #107.

2. During an observation of care, a PSW was observed leaving an identified room, without removing the PPE they were wearing. The PSW then entered another resident room that was on droplet and contact precautions without performing hand hygiene and applying the required PPE. The same PSW was then observed exiting the resident's room on droplet and contact precautions without removing their PPE or performing hand hygiene.

The PSW acknowledged that they were not following proper IPAC procedures.

The Infection Control Nurse acknowledged that the PSW did not follow the home's Infection Prevention and Control program, and that the PSW should have changed their PPE in between resident rooms, performed hand hygiene, and applied a gown, face shield, mask, and gloves when going into the room under droplet and contact precautions.

Sources: Observation of care; and interview with Infection Control Nurse #102.

The home may have been at an increased risk for infectious disease transmission, related to this non-compliance as proper infection prevention and control measures were not followed. [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 all staff participate in the implementation of the Infection Prevention and Control Program, 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. (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 home failed to ensure that toileting was provided to a resident as specified in their plan.

The resident required two staff assistance with toileting which included physically assisting the resident on and off the toilet.

During an observation of care, two PSWS were observed assisting the resident in their bathroom. The resident was observed to be on the toilet when PSW #110 left the room. The inspector then observed PSW #111 assist the resident in the bathroom on their own.

PSW #111 verified that the resident required two staff assistance with toileting and acknowledged they had assisted the resident with toileting on their own, including assisting the resident off the toilet.

There was a risk that the resident would not receive the care they required related to toileting as their plan of care was not followed.

Sources: Observation of care; and interview with PSW #111. [s. 6. (7)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The home failed to ensure that a resident's toileting was documented.

The resident required assistance with toileting at an identified interval.

During an observation of care, the resident's toileting was observed. The PSWs and the RPN on duty identified that toileting was documented on paper; however, in review of the documentation binder, the staff verified that a documentation form was not initiated for the resident. There was no documentation for the resident's toileting for an identified month.

The form used to document toileting included an ability to add information related to whether the resident was toileted, dry, incontinent, or if they refused care.

The DOC identified that they expected the resident's toileting to be documented.

There was a risk that an evaluation of the interventions for the resident's toileting may not be completed as the interventions and the resident's responses, were not documented.

Sources: Observation of care; review of documentation binder, interviews with PSW #111, PSW #112, RPN #113, and the DOC. [s. 30. (2)]

Issued on this 22nd day of December, 2021

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

Original report signed by the inspector.