Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Hamilton District
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Original Public Report

Report Issue Date: July 24, 2023	
Inspection Number: 2023-1296-0003	
Inspection Type: Proactive Compliance Inspection	
Licensee: Mirdem Nursing Homes Ltd.	
Long Term Care Home and City: Victoria Gardens Long Term Care, Hamilton	
Lead Inspector Lisa Vink (168)	**Inspector Digital Signature** Lisa Vink Digitally signed by Lisa Vink Date: 2023.07.24 12:21:19 -04'00'
Additional Inspector(s) Parminder Ghuman (706988) Lesley Edwards (506)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 12, 13, 14, 17, 18, 19 and 20, 2023.

The following intake was inspected:

- Intake: #00091701 - Proactive Compliance Inspection (PCI).

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement

Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (1) (a)

The licensee has failed to ensure that the written plan of care for a resident set out the planned care for the resident that included interventions related to heat related illness.

Rationale and Summary
A resident's assessment identified they were at risk for heat related illness.
Review of the plan of care did not include a focus statement or interventions related to how to prevent heat related illnesses for the resident.
The plan of care was amended to include a focus statement and interventions to prevent heat related illness.

Sources: Interview with staff and review of a resident's clinical record and policy titled "Heat Related Illness Prevention and Management Plan". [506]

Date Remedy Implemented: July 14, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident regarding transfers.

Rationale and Summary
A resident's plan of care identified they required a level of assistance for transfers.
The logo in the resident's room noted they required a different level of assistance for transfers.
Observation identified staff transferred the resident consistent with the posted logo.
Staff acknowledged the resident required the level of assistance provided for some time.
The plan of care was amended by staff following a review of the resident's status, to be consistent with the direction provided on the logo.

Sources: Plan of care and logo for a resident; observations of the resident and interviews with staff. [506]

Date Remedy Implemented: July 14, 2023

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 19

The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents could not be opened more than 15 centimetres (cm).

Rational and Summary
A window in a bedroom was unrestricted.
Staff repaired the restrictor immediately.

Sources: Observations and interview with staff. [506]

Date Remedy Implemented: July 12, 2023

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2022, was implemented.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that Additional Precautions were to be followed in the IPAC program which included (f) additional personal protective equipment (PPE) requirements including appropriate removal and disposal.
A staff was observed wearing PPE.
The staff acknowledged they had cleaned a resident's room who was on precautions and had not removed their PPE before they left the room, as required.
Failure to remove the PPE posed a risk of spreading an infection.

Sources: Observations of staff and a room; interview with staff. [506]

WRITTEN NOTIFICATION: Additional training - direct care staff

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 2.

The licensee has failed to ensure that all staff who provided direct care to residents received training on skin and wound care in 2022.

Rationale and Summary
The home's training records for 2022 identified that not all direct care staff completed the mandatory training as required related to skin and wound care.
There was a risk that not all direct care staff were familiar with the home's skin and wound care program when they failed to complete the annual training as required.

Sources: Review of Surge Course Completion reports and interview with staff. [168]

WRITTEN NOTIFICATION: Additional training - direct care staff

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 4.

The licensee has failed to ensure that all staff who provided direct care to residents received training on pain management in 2022.

Rationale and Summary
The home's training records for 2022 identified that not all direct care staff completed the mandatory training as required related to pain management, including pain recognition of specific and non-specific signs of pain.
There was a risk that not all direct care staff were familiar with the home's pain management program when they failed to complete the annual training as required.

Sources: Review of Surge Course Completion reports and interview with staff. [168]