Ontario

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

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

Hamilton District
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Original Public Report

Report Issue Date: April 11, 2024	
Inspection Number: 2024-1296-0001	
Inspection Type: Complaint Critical Incident	
Licensee: Mirdem Nursing Homes Ltd.	
Long Term Care Home and City: Victoria Gardens Long Term Care, Hamilton	
Lead Inspector Betty Jean Hendricken (740884)	**Inspector Digital Signature**
Additional Inspector(s) Jennifer Allen (706480)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 7, 8, 11-15 and 18, 2024.

The following intake(s) were inspected:

- Intake: #00100647 - critical incident related to Falls Prevention and Management.
- Intake: #00101797 - critical incident related to Medication Management.
- Intake: #00107194 - complaint related to Falls Prevention and Management and Prevention of Abuse and Neglect.
- Intake: #00107604 - critical incident related to Infection Prevention and Control.

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Training

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 10.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.

The licensee failed to ensure that registered staff received training on the use and storage of a medication before performing their responsibilities.

Rationale and Summary
On a date in November 2023, a resident experienced a medical event that required medication. Staff were unable to locate the required medication due to not being trained.

An interview with staff confirmed that not all direct care staff had the required education regarding use and storage of the medication.

Failure of the licensee to provide education on the use and storage of the medication, led to a negative outcome for a resident.

Sources: Resident's clinical records, Policy for Response to Hypoglycemic Emergencies, Policy for Emergency Drugs – Nasal Glucagon (Baqsimi), interviews with staff.
[740884]

WRITTEN NOTIFICATION: Required Programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (2) (b)
Required programs
s. 53 (2) Each program must, in addition to meeting the requirements set out in section 34,
(b) provide for assessment and reassessment instruments. O. Reg. 246/22, s. 53 (2).

The licensee failed to ensure that the falls prevention and management program provided for assessment and re-assessment tools.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that the Falls Prevention and Management program provided for assessment and re-assessment tools.
Specifically, the policy stated that a head injury assessment was to be implemented every time a resident was suspected of having a head injury, including after an unwitnessed fall and that all responses were to be documented on the Neurological

Monitoring Record.

Rational and Summary
On a day in October 2023, a resident fell and sustained an injury.

A Neurological Monitoring Record was not found in the resident's health records and it could not be confirmed that it was initiated at the time of fall.
A staff member stated that when a fall is unwitnessed a neurological assessment should be completed and should be continued upon the resident's return from hospital.

The DOC confirmed that following an unwitnessed fall, the nursing staff were to complete a Neurological Monitoring Record.

The risk of not completing a Neurological Monitoring Record is that neurological symptoms related to an unwitnessed fall may not be noticed.

Sources: Head Injury Routine Policy, resident's health records; interview with staff. [706480]

WRITTEN NOTIFICATION: Skin and Wound

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(ii) upon any return of the resident from hospital

The licensee failed to ensure that a skin assessment was completed when a resident returned from hospital.

Rationale and Summary
On a day in October, 2023, a resident sustained a fall requiring hospital transfer.

The home's Skin & Wound Care Program stated that a skin/wound assessment by a registered staff was to be completed upon any resident's return from hospital.

A review of the resident's health records could not verify that a skin assessment was completed when the resident returned from hospital.

The DOC confirmed that a skin assessment was required upon a resident's return from hospital and acknowledged it could not be located within the resident's health records.

Failure to ensure that a skin assessment was completed upon the resident's return from hospital put the resident at risk of skin alterations being undetected and delay in treatment and monitoring.

Sources: Skin & Wound Care Program, resident's health records; interview with staff.
[706480]