Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection 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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 5, 2018	2018_542511_0004	002609-18	Complaint

Licensee/Titulaire de permis

Haldimand War Memorial Hospital
206 John Street DUNNVILLE ON N1A 2P7

Long-Term Care Home/Foyer de soins de longue durée

Edgewater Gardens Long Term Care Centre
428 Broad Street West DUNNVILLE ON N1A 1T3

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

ROBIN MACKIE (511)

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): February 8, 9, 14, 2018.

This Inspection was completed concurrently with Follow-up Inspection 2018_542511_0003 / 026268-17, 026269-17, 026270-17, 026271-17, 026272-17

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Care, Registered staff inclusive of Registered Nurse(s) (RNs) and Registered Practical Nurse(s) (RPNs), Personal Support Workers (PSWs), MDS-RAI Coordinator, residents and family members.

During the course of the inspection, the Inspector toured the home, observed the provision of care, observed medication pass, meal service, reviewed clinical records, policies and procedures, the home's complaints process, investigative notes and conducted interviews.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	Legendé 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 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 licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #001's plan of care identified the resident was to be assisted with an activity of daily living after their meal. Resident #001 required total assistance of two staff for their activity of daily living.

On an identified day in 2018, the Inspector observed resident #001 after their meal service for approximately two and a half hours and they were not observed to be assisted with the identified activity of daily living, as per the plan of care.

Interview with PSW #104, #113 and #115 stated they were responsible for the resident's care on the identified home area. All three staff indicated they had not assisted resident #001 with their activity of daily living after the meal service. Staff #115 stated they had not asked the resident, on the identified day, if they wanted assistance with their activity of daily living.

The licensee had failed to ensure the care set out in the resident's plan of care was provided, as specified in the plan, when they were not provided assistance with their activity of daily living.

Issued on this 18th day of April, 2018

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

Original report signed by the inspector.