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 Office
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137
hamiltondistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: December 9, 2022	
Inspection Number: 2022-1446-0001	
Inspection Type: Complaint Follow up Critical Incident System	
Licensee: Haldimand War Memorial Hospital	
Long Term Care Home and City: Edgewater Gardens Long Term Care Centre, Dunnville	
Lead Inspector Emma Volpatti (740883)	**Inspector Digital Signature**
Additional Inspector(s) Betty Jean Hendricken (740884) Lesley Edwards (506)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s): November 16, 18, 21, 22, 23 and 24, 2022.

The following intake(s) were inspected:

- Intake # 00005907: Follow-up Compliance Order relating to administration of drugs
- Intake # 00005908: Follow-up Compliance Order relating to medication incidents and adverse drug reactions
- Intake # 00005992: Complaint regarding the prevention of abuse and neglect, communication strategies
- Intake # 00012871: Critical Incident System (CIS) report number 2963-000012-22 regarding an unexpected death

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

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Infection Prevention and Control
Food, Nutrition and Hydration
Prevention of Abuse and Neglect
Resident Care and Support Services
Medication Management

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	s. 131 (1)	2022-968920-0002	001	Lesley Edwards (#506)
O. Reg. 79/10	s. 135 (3)	2022-968920-0002	002	Lesley Edwards (#506)

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. 3 (1) 19. iv.

The licensee has failed to ensure that the rights of residents were fully respected and promoted, specifically to have their personal health information, within the meaning of the Personal Health Information Protection Act, kept confidential in accordance with that Act.

Rationale and Summary

Upon entry into the home on November 22, 2022, the Long Term Care Homes (LTCH) Inspector observed a clear garbage bag full of opened medication pouches which contained resident names, room numbers and the names of medications which were included in the pouches. At this time there were other visitors entering the home able to see the medication pouches.

When this was brought up to the Administrator/Director of Care (DOC), they immediately removed the bag from the front entrance.

Sources: observations; interview with Administrator/DOC.

Date Remedy Implemented: November 22, 2022.

[506]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 24 (1) 2.

The licensee has failed to ensure that the Director was immediately informed of alleged abuse of a resident. The Administrator/DOC had reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Rationale and Summary

The Administrator/DOC received a written complaint alleging lack of communication and treatment received.

Review of the Critical Incident System (CIS) revealed that a Critical Incident was not submitted to the Director. Interview with the Administrator/DOC confirmed they did not report the alleged abuse to the Director.

Sources: CIS; Interview with the Administrator/DOC

[740884]

WRITTEN NOTIFICATION: LICENSEE TO FORWARD COMPLAINTS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 22 (1)

The licensee has failed to ensure that a written complaint concerning the care of a resident was immediately forwarded to the Director.

Rationale and Summary

The Administrator/DOC received a written complaint alleging lack of communication and treatment received.

In interview with the Administrator/DOC, it was confirmed that the written complaint was not forwarded to the Director.

Sources: written complaint, interview with Administrator/DOC.

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WRITTEN NOTIFICATION: BINDING ON LICENSEES

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that that every operational or policy directive that applies to the long-term care home was carried out.

The Minister's Directive, titled Covid-19 Guidance Document for Long-Term Care Homes in Ontario, specifies that homes must ensure that all residents are assessed at least once daily for signs and symptoms of COVID-19, including temperature checks.

Rationale and Summary

The Infection Prevention and Control (IPAC) Lead stated that staff were performing COVID-19 symptom monitoring with temperature checks and it was documented on a physical document titled Resident Screening Tool at each nursing station. A Registered Practical Nurse (RPN) indicated that symptom monitoring, including temperature checks, was typically done by one of the Registered Nurses (RN) everyday.

A review of the assessments for the residents in the home from the period of October 1, 2022 to November 18, 2022 was conducted. On 34 days, there was missing temperatures for some or all residents. The Resident Assessment Instrument (RAI) Co-Ordinator, acknowledged that there were missing temperatures.

By not consistently ensuring that all residents are assessed at least daily for signs and symptoms of COVID-19, including temperature checks, there was a risk of not identifying signs and/or symptoms that may require additional action.

Sources: Interviews with the IPAC Lead, RAI Co-Ordinator and staff, review of the resident screening tool, Minister's Directive: COVID-19 response measures for long-term care homes (August 30, 2022), COVID-19 guidance document for long-term care homes in Ontario (October 14, 2022).

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WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

A. 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 Routine Precautions were to be followed in the IPAC program which included (d) the proper use of Personal Protective Equipment (PPE) including the appropriate selection, application, removal, and disposal.

The LTCH Inspector entered the home and observed the screener begin to perform a COVID-19 rapid test on a visitor. The screener was not wearing any eye protection, and after completing the rapid test, they completed hand hygiene with hand sanitizer over the gloves they were wearing. The screener then began to perform a COVID-19 rapid test on another visitor.

The screener acknowledged that they did not use the PPE properly and should have donned new gloves between testing visitors. They also acknowledged they should have been wearing eye protection while performing the rapid tests.

Failure to comply with the IPAC standard, to use PPE properly, may have increased the risk of infection transmission.

Sources: Interview with the screener, IPAC Standard for Long-Term Care Homes (April 2022), observations of the screener.

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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 routine precautions were to be followed in the IPAC program, which included (e) (ii) engineering controls, such as barriers.

The LTCH Inspector entered the home and observed the screener in front of the screening desk and they were within two meters of two visitors. The screener was not wearing eye protection and was not behind a plexiglass barrier.

The screener acknowledged that they should be wearing eye protection during screening if they are not behind a barrier and are within two meters of a visitor.

Failure to comply with the IPAC standard, to use engineering controls such as barriers, may have increased the risk of infection transmission.

Sources: Interview with the screener, IPAC Standard for Long-Term Care Homes (April 2022), observations of screener.

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COMPLIANCE ORDER CO #001: DUTY TO PROTECT

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. Provide education for all Registered Nursing Staff, Personal Support Workers, the Food Services Supervisor and the Registered Dietitian on:

- The definition and meaning of neglect; and
- Why this incident met the definition of neglect; and
- The importance of reporting discrepancies between diet textures being sent and the diet texture that is ordered; and
- The process for how to collaborate if there is any unclear referrals sent to the Dietitian; and

2. Document the education, including the date it was held, the staff members who attended and the staff's signatures that they understood the education. Also include who provided the education; and
3. The home must keep a record of this education for the LTCH Inspector to review.

Grounds

The licensee has failed to ensure that a resident was protected from neglect.

O.Reg 246/22 s. 7 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary

On an identified date in 2022, the Registered Dietitian (RD) ordered a diet texture change for the resident. The Food Services Supervisor (FSS) made all the required changes for the texture change, however, did not make the required changes to the snack list. The resident continued to receive their labeled old texture snack on the cart from the time the resident's diet texture was changed until 77 days later.

Interview with three Personal Support Workers (PSWs) confirmed they were aware that the resident was on a new texture and that the resident continued to receive the old labeled snack on the snack cart. Two of the three PSWs confirmed they either gave the resident their new texture for a snack or they were not provided a snack at all, and they also stated they did not report the wrong texture being sent on the snack cart to anyone.

One of the three PSWs confirmed they did report this to registered staff and that at times registered staff provided direction to give the old texture to the resident, however, this could not be confirmed with registered staff.

An RPN acknowledged that on some occasions, registered staff would give different textured snacks to the resident under supervision.

On another identified date, a Dietitian referral was sent to the RD by an RPN asking that the resident be provided their new texture for the evening snack. Interview with the RD confirmed that they spoke with

the FSS to make sure that they were providing the floor with the new texture on the snack cart. The RD confirmed they did not ask if they were providing the new texture specifically for the resident as they felt the referral was not clear. They tried to follow up with the RPN but they were not working at that time. The RD closed the referral with no notes or further action, and the resident continued to receive their old texture snacks on the cart.

Seventy-seven days after the RD initially changed the diet texture, two PSWs were completing the snack cart. One PSW gave the other PSW the old texture snack to give to the resident. The PSW confirmed they knew that the resident was on a new texture but because of previous instruction to give the old texture, they gave it to the resident.

An RPN was completing a medication pass outside of the resident's room and noticed the resident was eating their old texture snack. They then began to prepare the resident's medication for administration and when they looked back at the resident, they realized the resident experienced a change in condition. The RPN confirmed they knew the resident was supposed to be a on a new texture but was provided their old texture snack. The resident was immediately provided treatment. The resident's condition then further deteriorated.

The paramedics were called and upon arrival to the home, and the resident was pronounced deceased.

The home failing to provide the resident with the care and services required for health and safety and included the pattern of inaction that jeopardized the health, safety, and well-being of the resident, caused significant harm to the resident.

Sources: Interviews with PSWs, RPNs, the RD, the FSS and the Food Services Manager (FSM), the resident's progress notes and care plan, the LTCH's investigation notes, CI report #2963-000012-22, the resident's dietitian referral form and order sheet, Edgewater Gardens Dietitian and Food Services Communication Tool, progress notes by the RD, the resident's snack label, the resident's advanced care directives.

[740883]

This order must be complied with by

January 19, 2023

COMPLIANCE ORDER CO #002: NUTRITIONAL CARE AND HYDRATION PROGRAMS

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O.Reg. 246/22, s. 74 (2) (c)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. Educate the Food Services Supervisor on the process to be followed when dietary texture changes are made by the Registered Dietitian; and
2. Document the education, including the date it was held and the Food Services Supervisor's signature that they understood the education; and
3. Complete an audit of the snack list for all residents. Included in the audits should be any discrepancies noted, how they were fixed, a corrective action plan and education provided to the staff who made the discrepancy; and
4. Establish a permanent routine auditing schedule for the Food Services Manager and Food Services Supervisor to audit the snack list of all residents; and
5. The home must keep a record of the education, schedule, and audit for the LTCH Inspector to review.

Grounds

The licensee has failed to ensure that the program's interventions to mitigate and manage risks relating to a resident's nutritional care, dietary services and hydration were implemented.

In accordance with O.Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that the Nutrition and Hydration program's interventions to mitigate and manage risks relating to nutritional care and dietary services and hydration are implemented.

Specifically, staff did not comply with the policy "Dietitian Communication Tool", revised July 2021, which was included in the licensee's Nutrition and Hydration program.

Rationale and Summary

The RD ordered a diet texture change for a resident. The FSS made all the required changes in the meal service notes for the texture change, however, did not make the required changes to the snack list. The resident continued to receive their old texture snack on the snack cart from the time the resident's diet texture was changed until seventy-seven days later.

The home's policy titled Dietitian Communication Tool indicated that the RD would record any changes made to a resident's nutritional plan of care on the communication tool. The RD would then provide this communication tool to the FSS at the end of each facility visit. The FSS would then communicate all changes to the dietary staff through the meal service notes.

Review of the communication tool indicated that the resident's diet order was changed. The FSS initialed next to the change and dated it, however, the check boxes were not filled out under food services department to ensure completion.

Interview with the FSS confirmed that they did not follow the process of updating the meal service notes and snack notes to reflect the RD's change of the diet texture for the resident.

The home failing to ensure that the interventions to mitigate and manage risks relating to the resident's nutritional care, dietary services and hydration were implemented, may have caused significant harm to the resident.

Sources: interview with the FSS and RD, the home's policy titled Dietitian Communication Tool, Edgewater Gardens dietitian and food services communication tool, the resident's progress notes, care plan and order sheet, the resident's snack label, LTCH's investigation notes.

[740883]

This order must be complied with by

January 19, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care

438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor

Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.