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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: April 16, 2024	
Inspection Number: 2024-1446-0002	
Inspection Type: Critical Incident	
Licensee: Haldimand War Memorial Hospital	
Long Term Care Home and City: Edgewater Gardens Long Term Care Centre, Dunnville	
Lead Inspector Erin Denton-O'Neill (740861)	Inspector Digital Signature Erin Denton-O`Neill Digitally signed by Erin Denton-O`Neill Date: 2024.04.16 14:57:05 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 27 - 28, 2024, April 3 - 4 and 9 - 11, 2024.
The inspection occurred offsite on the following date(s): April 5 and 8, 2024.

The following intake(s) were inspected:

- Intake: #00111290 - Critical Incident (CI) #2963-000003-24 - related to an allegation of abuse of a resident
- Intake: #00099470 - CI #2963-000011-23 - related to an allegation of abuse of a resident
- Intake: #00099487 - CI #2963-000012-23 - related to an allegation of abuse of a resident
- Intake: #00100348 - CI #2963-000013-23 - related to falls prevention and management

The following intakes were completed in this inspection:

- Intake: #00088656 - CI #2963-000005-23 - related to falls prevention and management

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
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)
Non-compliance with: FLTCA, 2021, s. 82 (4)
Training
s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The licensee has failed to ensure that all staff received annual retraining related to the long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

Rationale and Summary
FLTCA, s. 82 (4) identified that every licensee shall ensure that the persons who have received training under subsection (2) (3), the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. O Reg 246/22 s. 260. (1) The intervals for the purposes of subsection 82 (4) of the Act are annual intervals.

A review of annual staff training records for a 15-month period and interviews with the Director of Care (DOC) indicated that two staff employed by the home did not receive their annual training on the policy and duty outlined in the above paragraph. Failure for the home to provide annual training to the required individuals increased the risk of staff not understanding their responsibilities, as set out in the home's training program.

When this was brought to the attention of the DOC, they immediately contacted the staff, brought them in and completed the retraining that day.

Sources: Annual staff training records and interviews with DOC
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Date Remedy Implemented: April 11, 2024

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 3.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right to have their participation in decision-making respected.

The Licensee has failed to ensure that a resident had their right to participation in decision-making respected.

Rationale and Summary:
A resident was not invited to participate in their care conference and was not asked to give consent to treatments or care. Family members who were not the resident's substitute decision maker (SDM) were invited to the resident's care conference and for several months were asked by the home to give consent for care related decisions when the resident may have been capable of making these decisions. This was confirmed by staff and the Director of Care (DOC).

Sources: Resident's clinical records, power of attorney for personal care and interviews with DOC, police and staff.
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WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. 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.

The licensee has failed to ensure immediate reporting to the Director of the suspected abuse of a resident that resulted in harm or risk of harm.

Rationale and Summary:
Critical Incident (CI) reports were submitted on three separate occasions in relation to incidents of alleged abuse and were not reported to the Director on the day that they occurred. In two instances an after-hours report was made on the following day on which incidents occurred. In one other instance there was no after hours reporting and a CI report was made to the Director two days after the incident occurred. The nurse and Director of Care (DOC) were made aware of the incidents on the day on which they occurred, and the DOC acknowledged that the incident was not immediately reported to the Director.

Sources: Interviews with resident, staff; CI Reports; internal investigation notes and resident's clinical record.
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