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

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Public Report

Report Issue Date: December 23, 2024

Inspection Number: 2024-1446-0003

Inspection Type:
Critical Incident

Licensee: Haldimand War Memorial Hospital

Long Term Care Home and City: Edgewater Gardens Long Term Care Centre, Dunnville

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: December 2-6, 9-11, and 13, 2024

The following intakes were inspected:

- Intake: #00119642/CI #2963-000007-24 was related to falls prevention and management
- Intake: #00125188/CI #2963-000009-24 was related to prevention of abuse and neglect
- Intake: #00127196/CI #2963-000011-24 was related to responsive behaviours

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the plan of care for the resident provided clear directions to staff.

Rationale and Summary
The plan of care for the resident related to room checks did not provide clear directions to staff on how to conduct room checks. During an interview with staff, it was acknowledged that that plan of care related to room checks for the resident did not provide clear directions to staff.

Sources: Current plan of care for the resident; family note; interview with staff.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that care was provided as specified in the plan of care related to the residents' responsive behaviours.

Rationale and Summary
The plan of care for the resident indicated that hourly safety checks were to be completed related to the resident's responsive behaviours. On a specific date, as per clinical records hourly checks for the resident were not completed and the resident engaged in self-harm during that time. It was confirmed during an interview with staff that hourly checks for resident were not completed.

Failure to ensure the plan of care was followed provided an opportunity for the resident to engage in self-harm.

Sources: Documentation survey report, plan of care; progress notes post-incident; interview with staff.

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that the plan of care was updated when the care set out in the plan was no longer necessary

Rationale and Summary
The residents' plan of care included interventions that were no longer necessary. During an interview with staff, it was confirmed that the identified items were no longer necessary as they had been either discontinued or completed and should not be included in the residents' current plan of care.

Sources: Review of resident plan of care; interview with staff.

WRITTEN NOTIFICATION: Duty to protect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that resident B was protected from sexual abuse by resident A.

Section 2 of the Ontario Regulation 246/22 defined sexual abuse as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

Rationale and Summary
Resident A was found touching resident B inappropriately. Interventions to respond to resident A's responsive behaviours were in place but failed to protect resident B was from abuse.

Sources: Critical Incident report #2963-000009-24; progress notes from the incident; plan of care for resident A and B; interview with staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when the resident had a fall that a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary
The resident had an unwitnessed fall in their room where they sustained multiple injuries. During an interview with the Director of Care it was confirmed that the home failed to conduct the appropriate post-fall assessments.

Failure to conduct the appropriate assessments post-fall put the resident at an increased risk for injury.

Sources: Record review of assessments conducted post fall in PCC; review of the resident's physical chart; review of the home's fall prevention and management policy, revised February 2020; resident plan of care; interview with Director of Care.

WRITTEN NOTIFICATION: Responsive behaviours

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to implement interventions to respond to the residents' responsive behaviours.

Rationale and Summary
A) Review of the resident's progress notes indicated that they had demonstrated responsive behaviours. The residents plan of care did not include interventions related to these responsive behaviours. Interviews with staff confirmed that the home was aware that the resident exhibits responsive behaviours and that their plan of care did not include interventions to address these behaviours. The homes failure to implement interventions to address the residents' responsive behaviours prevented the needs of the resident from being met.

Sources: Review of resident plan of care; progress notes demonstrating responsive behaviours; interviews with staff.

The licensee has failed to ensure that assessments and reassessments related to the residents' responsive behaviours were completed.

Rationale and Summary
B) Behavioural Supports Ontario Dementia Observation System (BSO DOS) data collection sheet was ordered by Hamilton Niagara Haldimand Brant Behavioural Supports Ontario (HNHB BSO) for 5 days and was not completed. It was reordered by HNHB BSO for 5 days starting on a specified date in August 2024. Review of the

BSO DOS data collection sheet noted that there was missing documentation. During an unrecorded interview with staff, it was confirmed that BSO DOS data collection sheet was not completed.

Failure to complete the BSO DOS collection sheet posed a risk of the residents' responsive behaviours not being identified.

Sources: Progress notes from HNHB BSO; BSO DOS data collection sheets; unrecorded interview with staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes, revised September 2023" (IPAC Standard). Additional Requirement 10.4 (d i. under the IPAC standard directs the licensee shall also include monthly audits of adherence to the four moments of hand hygiene by staff.

Rationale and Summary
Record review of the home's hand hygiene audits failed to locate staff hand hygiene

audits for June, September and October 2024. During an unrecorded interview conducted with staff it was confirmed that hand hygiene audits were not completed every month.

Failure to ensure monthly staff hand hygiene audits were completed put the residents at an increased risk of infection transmission.

Sources: Staff hand hygiene audits and interview with staff.

WRITTEN NOTIFICATION: Police notification

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee has failed to ensure police services were notified immediately after an act of witnessed sexual abuse

Rationale and Summary
Staff witnessed a resident touching another resident inappropriately. The home was made aware of the incident but did not notify police services as indicated in the home's abuse and neglect policy. During an interview with the Director of Care it was confirmed that police services were not informed of the incident and that they should have been notified. Failing to notify police services may have impacted the investigation into the abuse.

Sources: Review of homes policy on abuse and neglect; Critical Incident report; review of progress notes from the incident on Point Click Care; Interview with the Director of Care.

WRITTEN NOTIFICATION: Evaluation

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 106 (b)
Evaluation
s. 106. Every licensee of a long-term care home shall ensure,
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.

The licensee has failed to review the homes policy on abuse and neglect annually to ensure effectiveness and that improvements are made to prevent further reoccurrences of abuse.

Rationale and Summary
A review of the homes abuse and neglect policy noted that the date last revised was January 2017 and the policy included references to Long-Term Care Homes Act, 2007, S.O. 2007, c. . During an interview with the Director of Care it was confirmed that the policy had not been reviewed in the last year. An unrecorded interview with Director of Care confirmed that the date the policy was last reviewed was January 2017.

The licensee's failure to evaluate the home's policy on abuse and neglect on an annual basis negatively impacts the care the residents receive.

Sources: Review of the abuse and neglect policy, revised January 2017; recorded and unrecorded interviews with the Director of Care.