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 # / Registre no	Type of Inspection / Genre d'inspection
Oct 20, 2016	2016_342611_0020	028403-16	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF HALDIMAND COUNTY
45 Munsee Street Box 400 Cayuga ON N0A 1E0

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

GRANDVIEW LODGE / DUNNVILLE
657 LOCK STREET WEST DUNNVILLE ON N1A 1V9

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

KELLY CHUCKRY (611), IRENE SCHMIDT (510a), KERRY ABBOTT (631), YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): September 26, 27, 28, 29, 30, October 4, 5, 6, 2016.

During the course of this inspection, inspectors conducted a tour of the home, observed the provision of resident care, including meal service observations, reviewed relevant clinical records, conducted interviews, and reviewed relevant policies, procedures, and practices within the home.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, the Facilities Operations Manager, Program Supervisor, the Food Service Supervisor, registered staff, dietary staff, Personal Support Workers (PSW's), housekeepers, residents, and family members. In conjunction with this Resident Quality Inspection (RQI), a total of two (2) complaint inspections and seven (7) Critical Incident inspections were conducted. The complaint inspections were log #005486-16 related to resident abuse, and Log # 024613-16 related to food quality and medication administration. The critical incident inspections included Log #033091-15 related to plan of care and falls prevention, Log #005983-16 related to the complaint process, Log #013326-16 related to falls prevention, Log #016564-16 related to resident abuse, Log #021796-16 related to resident abuse, Log #022508-16 related to falls prevention, and log #023469-16 related to resident abuse.

The following Inspection Protocols were used during this inspection:

Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Trust Accounts

During the course of this inspection, Non-Compliances were issued.

- **5 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #002	2015_341583_0015	510a
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2016_188168_0010	611
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2015_341583_0015	510a
O.Reg 79/10 s. 8. (1)	CO #003	2015_341583_0015	631

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 O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were labelled properly and were kept inaccessible to residents at all times.

On September 26, 2016, at 1000 hours while conducting an initial tour of the home, Inspector #631 observed two unlocked housekeeping storage doors on two identified resident home areas. Both doors had a keypad type locking mechanism. The keypad mechanisms were observed to be malfunctioning as the Inspector was able to open both doors several times without activating the keypad. Both doors had signs posted stating that the rooms must remain locked. The Inspector observed a supply of a cleaner on the shelves in both rooms, and this cleaner is considered harmful if digested and may cause acute toxicity if swallowed.

An interview with staff #117 confirmed that the door was unlocked, that the chemicals were in the room and that the door should be kept locked at all times. On an identified date, the Inspector informed the Administrator about the two unlocked doors and the Administrator confirmed that the doors should be locked at all times. The Facility Operations Manager confirmed with the inspector that the chemicals were removed from the storage rooms immediately after the inspector reported the situation and that the locks to both doors were being repaired. [s. 91.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a dining and snack service that included, at a minimum, the following elements: proper techniques to assist residents with eating, including safe positioning of residents who required assistance.

A. On an identified date, during lunch observation on an identified resident home area, resident #500 was sitting in their tilted wheelchair in a reclined position. An interview with staff member #103, who provided assistance with eating for the resident, identified that the resident's tilted chair was supposed to be removed from the reclined position.

The interview with staff #110 and with the Food Service Manager confirmed that residents are to be in upright position during eating unless special positioning was indicated in their plan of care.

B. On two identified dates, during lunch observations on an identified resident home area, resident #501 and #502 were provided the required assistance by staff member #103, who was standing beside each resident at the time of providing assistance with feeding.

An interview with the staff member #103 identified that all residents were to be fed by staff seated beside the resident. The interviews with staff #110 and the Food Service Supervisor confirmed that residents were to be fed by staff seated beside the residents. [s. 73. (1) 10.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (b) were notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

A. A Critical Incident Report reported an incident of abuse involving residents #201, #202, #203, #204, #205, and #207. Residents #204, #205 and #207 all had cognitive performance scores (CPS) of greater than three out of six, indicating moderate cognitive impairment. Review of the critical incident submission and the clinical records for these residents revealed that the substitute decision makers for these residents were not notified of the suspected abuse. This was confirmed by the administrator.

The residents SDM's were not notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

B. A Critical Incident Report reported an incident that was submitted to the MOHLTC on an identified date by the home. Review of the documentation related to the critical incident indicated that the residents' substitute decision-maker, were not notified within 12 hours upon the licensee becoming aware of the suspected incident of financial abuse, which was confirmed by the home's Administrator. [s. 97. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that included:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant?

On an identified date, a family member of resident #300 reported that this resident was missing a personal item. The family member reported that the personal item was present the previous evening. A report of lost articles/money form was completed on an identified date, upon immediately becoming aware of the missing item.

A review of the 2016 complaint log provided by the home did not reveal a record of this complaint. As a result, the home did not document the nature of the complaint, the date the complaint was received, the type of action taken to resolve the complaint, the final resolution, dates responses were provided to the complainant, and any responses made by the complainant.

An interview conducted with the Administrator confirmed that this complaint was not captured in the homes complaint log. [s. 101. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control Program.

On an identified date, during resident room observations on an identified resident home area, there were several unlabelled residents' personal items found on the top of counter tops in several residents' shared bathrooms.

An interview with staff #104 and the Director of Nursing identified that residents' personal items were to be labeled. Staff member #104 confirmed that those residents' personal items were not labeled. The home's staff did not participate in the implementation of the Infection Control and Prevention Program policies and procedures. [s. 229. (4)]

Issued on this 27th day of October, 2016

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

Original report signed by the inspector.