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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 6, 2018	2018_569508_0020	026414-18	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

ROSEANNE WESTERN (508), CATHY FEDIASH (214), KELLY CHUCKRY (611)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 1, 2, 3, 4, 9, 10, 11, 12, 15, 16, 17, 18, 19, 2018.

During the course of the inspection, the inspectors toured the facility, observed meal service, observed the provision of care, reviewed resident clinical records, relevant policies and procedures, staffing schedules, Resident Council minutes and Family Council minutes.

The following Critical Incident (CI) inspections were conducted concurrently during this RQI:

- Log #001480-18, related to alleged resident to resident abuse;
- Log #011055-18, related to a fall resulting in injury;
- Log #010749-18, related to alleged resident to resident abuse;
- Log #005248-18, related to fall resulting in injury;
- Log #009433-18, related to fall resulting in injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Resident Assessment Instrument (RAI) Coordinator, Nursing Quality Assurance Lead, Program Supervisor/Staff Development Coordinator, Supervisor Facility Operations, Registered Staff, Personal Support Workers (PSWs), residents and family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **3 WN(s)**
- **1 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	Légende 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. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy to minimize the restraining of residents, was complied with.

A review of the home's policy, titled, "Minimizing Restraining of Residents: Use of Restraints" (Procedure Number 27-1.0 and dated as last reviewed April 2017), indicated under "Implement", that the interdisciplinary team would:

"Document every hour on restraint monitoring record and every 2 hours when the restraint is released and the resident is repositioned and care plan interventions have been followed."

During an observation of resident #004 on two identified dates in October, 2018, it was observed that the resident had a specific restraint in place while they were up in their wheelchair.

A review of a paper document titled, Restraint Assessment, and observed to be the most current assessment, indicated that the resident used a specific restraint as an intervention and as per family request.

A review of the resident's current electronic care plan in Point Click Care, indicated that resident #004 had a specific restraint while up in their wheelchair for safety, related to sliding and falling out of their wheelchair.

On an identified date in October, 2018, at 1230 hours, the document, titled, Restraint Flow Sheet, used to document application and removal of the restraint; hourly checks while restrained; release of the restraint and repositioning of the resident every two hours and the resident's response while restrained, was reviewed. It was observed that the flow sheets for the day shift contained hourly time frames from 0700 – 1400 hours, for staff to document under. A review of the day shift documentation on an identified date in October, 2018, indicated that documentation had been completed on the resident's restraint flow sheet for the full day shift from 0700 – 1400 hours.

An interview at 1245 hours, with registered staff #106, indicated that staff were to document on the Restraint Flow Sheet, following restraint care provided and were not to document ahead of care provided. An interview with the Nursing Quality Assurance lead and the RAI Coordinator at 1300 hours, indicated that staff were not to document ahead

of restraint care provided. The Nursing Quality Assurance lead confirmed that the home's policy in relation to minimizing restraining of residents, had not been complied with. [s. 29. (1) (b)]

2. The licensee failed to ensure that the written policy to minimize the restraining of residents, was complied with.

A review of the home's policy, titled, "Minimizing Restraining of Residents: Use of Restraints" (Procedure Number 27-1.0 and dated as last reviewed April 2017), indicated under "Implement", that the interdisciplinary team would:

"Document every hour on restraint monitoring record and every 2 hours when the restraint is released and the resident is repositioned and care plan interventions have been followed."

During an observation of resident #008 on two identified dates in October, 2018, it was observed that the resident had a specific restraint in place while they were up in their wheelchair.

A review of a paper document titled, Restraint Assessment, and observed to be the most current assessment, indicated that the resident used a specific restraint for identified reasons.

A review of the resident's current electronic care plan in Point Click Care on an identified date in October, 2018, indicated that resident #008 had a specific restraint while up in their wheelchair for safety..

On an identified date in October, 2018, at 1230 hours, a review of a paper document, titled, Restraint Flow Sheet, used to document application and removal of the restraint; hourly checks while restrained; release of the restraint and repositioning of the resident every two hours and the resident's response while restrained, was reviewed. It was observed that the flow sheets for the day shift contained hourly time frames from 0700 – 1400 hours, for staff to document under. A review of the day shift documentation on this date, indicated that documentation had been completed on the resident's restraint flow sheet for the full day shift from 0700 – 1400 hours.

An interview at 1245 hours with registered staff #106, indicated that staff were to document on the Restraint Flow Sheet, following restraint care provided and were not to

document ahead of care provided. An interview with the Nursing Quality Assurance lead and the RAI Coordinator at 1300 hours, indicated that staff were not to document ahead of restraint care provided. The Nursing Quality Assurance lead confirmed that the home’s policy in relation to minimizing restraining of residents, had not been complied with. [s. 29. (1) (b)]

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 the written policy to minimize the restraining of residents, is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.   O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements were met where a resident was being restrained by a physical device under section 31 of the Act: 1. that staff only applied the physical device that had been ordered or approved by a physician or registered nurse in the extended class.

During an observation of resident #008 on two identified dates in 2018, it was observed that the resident had a specific restraint in place while they were up in their wheelchair.

A review of a paper document titled, Restraint Assessment, and observed to be the most current assessment, indicated that the resident used a specific restraint for identified reasons.

A review of the resident’s current electronic care plan in Point Click Care on an identified date in October, 2018, indicated that resident #008 had a specific restraint while up in their wheelchair for safety..

A review of a paper document, titled, “Physician’s Medication Review”, over a three month period in 2018, indicated a physician’s order was in place for a specific restraint while in wheelchair. A review of the most current Physician’s Medication Review, indicated that no order for this restraint while in wheelchair was present. A review of the resident’s physician’s orders from the most recent Physician’s Medication Review for 2018, up to and including the date it was reviewed in October, 2018, had not identified an order in place for the resident’s restraint.

An interview with registered staff #106, indicated that an order for the restraint, while up in wheelchair was unable to be located. Registered staff #106 indicated that transcription of the order from the previous physician’s medication review must have been omitted when preparing the current physician’s medication review. Registered staff #106 indicated that a telephone call would be placed to the resident’s physician for an order for the restraint.

A review of the resident’s clinical record on an identified date in October, 2018, indicated that a physician’s telephone order for the restraint had been obtained on this date.

An interview with the Nursing Quality Assurance lead, confirmed that resident #008 had a specific restraint in place for which there was no order or approval by a physician or registered nurse in the extended class. [s. 110. (2) 1.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A review of the medication incident reports over a three month period in 2018, indicated that a medication incident was noted that involved resident #014. A review of the clinical health record for resident #014 took place on two identified dates during this inspection. This resident had an order to receive a medication every four hours as required for pain. On an identified date in 2018, resident #014 was administered this medication at their request for pain. This medication was inadvertently taken from the medication card for resident #015. It was the same medication; however, it was a lower dosage then what had been prescribed for resident #014.

Further review of the health records indicated that the lower dosage of this medication administered to resident #014 was effective, and this resident did not have complaints of pain as a result of the lower dose being administered.

In an interview conducted with registered staff #120, and an interview with registered staff #126, it was confirmed that resident #014 did not receive their medications in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Issued on this 14th day of November, 2018

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

Original report signed by the inspector.