Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Dec 1, 2020	2020_556168_0017	005177-20, 015784-20	Critical Incident System

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

LISA VINK (168)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 28, 29, 2020 and November 2, 3, 4 and 5, 2020.

This inspection was completed for the following intakes:
005177-20 - related to Critical Incident Report M532-000004-20 for transferring and positioning techniques; and
015784-20 - related to Critical Incident Report M532-000007-20 for transferring and positioning techniques.

PLEASE NOTE: Findings of non-compliance related to LTCHA, 2007, c.8, s. 6 (10) b were identified in this inspection and have been issued in Complaint Inspection Report 2020_556168_0016, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the maintenance supervisor, a staff member, registered practical nurses (RPN), personal support workers (PSW) and residents.

During the course of the inspection, the inspector toured the home, observed the provision of care, reviewed a video and reviewed relevant documents including but not limited to: training records, procedures and clinical health records.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for residents.

The home was equipped with areas which were locked from the hallway, at all times, with doors that automatically locked upon closure.
Staff interviewed confirmed that residents were not to be left unattended in the areas.
The areas included supplies and or equipment which were to be used on or for residents with the supervision or assistance of staff.

A resident was left unattended in the area, where staff provide care, seated on stationary chair for a short period of time by a staff member, behind a closed door.

The resident was not to be left unattended in the area.

Sources: Critical Incident Report, progress notes, observations of the home and interviews with staff. [s. 5.]

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 home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used all equipment in accordance with manufacturers' instructions

The home operated a wheelchair van to transport residents to appointments and other activities.
The home provided manufacturers' instructions to secure passengers in the van, when in a wheelchair.
The video identified how to secure residents into the van.
Staff demonstrated the procedure that they followed when they secured resident's as passengers in the van.
The demonstration was not consistent with the manufacturers' instructions.
The staff member confirmed that at times they followed the manufacturers' instructions and other times they secured the resident(s) by another method depending on a number of factors.

According to the clinical record a resident was not fully secured for a period of time when they were transported in the van.

If the manufacturers' instructions are not followed there would be a risk of falls or injury to the resident(s).

Sources: A review of the clinical records, review of video, demonstration and interview with staff. [s. 23.]

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 staff use all equipment in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident fell they were assessed and a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

The definition of a fall according to the Minimum Data Set (MDS) assessment included that "the distance to the next lower surface was not a factor" to determine a fall.

A review of the progress notes identified that a resident was involved in an incident where they were on their knee and required staff assistance to stand up.
The record did not include a post fall assessment, which would have included an assessment of some vital signs, related to this incident.

The clinically appropriate assessment instrument for falls, required staff to review the resident's history of falls and other contributing factors to assist in establishing interventions in an effort to prevent re-occurrence.

Sources: Progress notes and post fall screening tools and interviews with staff. [s. 49. (2)]

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 when a resident falls they are assessed and, if required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 3rd day of December, 2020

[redacted]

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

Original report signed by the inspector.