**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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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l’inspection | Log # / No de registre | Type of Inspection / Genre d’inspection |
|---|---|---|---|
| Jun 21, 2021 | 2021_569508_0012 | 021394-20, 003285-21, 003385-21, 007078-21, 008785-21 | 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**

ROSEANNE WESTERN (508), AILEEN GRABA (682)

## 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): May 31, June 1, 2, 3, 7, 9, 10, 11, 2021 (on-site), June 4, 8, 15 and 16, 2021 (off-site).

During the course of the inspection, the inspectors toured the facility, observed the provision of care, reviewed resident clinical records, investigative notes, relevant policies and procedures and education records.

The following intakes were inspected during this inspection:

- Log #003385-21, related to fall prevention and management;
- Log #021934-20, related to resident to resident abuse;
- Log(s) #008785-21, 007078-21, 003285-21, related to unexpected deaths.

Please note: Complaint inspection #2021_704682_0009 was inspected concurrently during this Critical Incident (CI) inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing (DON), Assistant Director of Nursing (ADON), Resident Assessment Instrument (RAI) Coordinator, registered staff, Personal Support Workers (PSW), residents and family members.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 19. Duty to protect**

**Specifically failed to comply with the following:**

**s. 19. (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. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that resident #002 was protected from neglect.

For the purposes of the Act and this Regulation, neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A Critical Incident (CI) Report was submitted to the Director in 2021 related to the neglect of a resident.

Resident #002 was transferred to bed after their meal by two PSW staff. The staff identified that the resident had a change in condition. PSW #104 reported this to the Registered Practical Nurse (RPN) who did not assess the resident and directed staff to provide an intervention.

The RPN then stated they were going for break without assessing the resident and left the unit. The PSWs stayed with the resident while the RPN was on break; however the resident's condition deteriorated. The PSWs did not call for the Registered Nurse (RN) or a nursing manager during this time. When the RPN returned to the unit thirty minutes later, they were informed of the resident’s deteriorating condition by another PSW; however, the RPN again did not immediately assess the resident.

During interview with the ADON, she indicated that when the RPN had returned to the unit after break, the RPN failed to immediately assess the resident despite knowing they had a change in condition and had attended to another resident before going to assess resident #002.

An investigation concluded that although the PSWs reported the resident’s change in condition to the RPN, they failed to further report the resident’s condition to the RN or a nursing manager when the resident continued to deteriorate while the RPN was on break.

The licensee failed to protect this resident from neglect when the resident had a change in condition and staff failed to assess the resident and provide treatment in a timely manner.

Sources: Critical Incident Report #M532-00003-21, investigative notes, interview with Administrator. [s. 19. (1)]

***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 residents are protected from neglect, to be implemented voluntarily.***

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**Issued on this 30th day of June, 2021**

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

**Original report signed by the inspector.**