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
Oct 8, 2021	2021_911506_0005	010053-21	Complaint

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

LESLEY EDWARDS (506), LISA VINK (168)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 22, 23, 24, 28, 29 and October 1, 2021.

This inspection was completed related to the following Complaint intake:

Log #010053-21- related to skin and wound, personal support services, nutrition and hydration, housekeeping, infection control, pain and prevention of abuse and neglect.

This inspection was conducted concurrently with Critical Incident Inspection #2021_911506_0004.

During the course of the inspection, the inspector(s) spoke with Administrator, Associate Director of Care (ADOC), Registered Dietitian (RD), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), Resident Assessment Instrument (RAI) Coordinator, Physician, housekeeping staff, Quality Nurse, residents and family.

During the course of the inspection the inspector toured the home, completed an infection prevention and control assessment (IPAC) checklist, reviewed clinical records, consult notes, policies and procedures, photographs, observed the provision of care and conducted interviews.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Infection Prevention and Control
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Skin and Wound Care

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

7 WN(s)
4 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. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The licensee has failed to ensure that the plan of care was provided to a resident as specified in the plan.

The written plan of care for the resident identified that they had a care plan in place to monitor a medical condition and to report to the physician any signs and symptoms of the medical condition.

On an identified date in June 2021, it was brought to the staff's attention that the resident was experiencing a change in condition. The staff monitored the resident for several days and the physician assessed on their next visit to the home. Staff interviews confirmed they did not follow the plan of care.

Sources: resident's clinical record including the written plan of care and interviews with staff [s. 6. (7)]

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 plan of care is provided as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee has failed to ensure the resident weight policy and procedure was complied with.

LTCHA s.11 (1) requires an organized program of nutrition care and dietary services.

O. Reg. 79/10, s. 68 (2) (e) (i) requires that the program includes a weight monitoring system to measure and record weight on admission and monthly thereafter for each resident.

Specifically, staff did not comply with the home's policy and procedure 'Resident Weights'.

A review of the clinical record confirmed the resident did not have a weight completed in August 2021.

The policy stated, "PSW staff are to weigh residents in the first week of every month on their bath days and to be recorded in point of care software". The RD confirmed that the home's policy was not followed for resident #001.

By not having a monthly weight for the resident, a proper assessment of potential weight changes could not be completed to assist with identifying the need for any nutrition interventions.

Sources: resident's clinical record, the home's policy 'Resident Weights' (dated December, 2020), interview with RD and staff. [s. 8. (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 policies and procedures are followed, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (1) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents; and 2007, c. 8, s. 11. (1).
(b) an organized program of hydration for the home to meet the hydration needs of residents. 2007, c. 8, s. 11. (1).

Findings/Faits saillants :

The licensee has failed to ensure that there was an organized program of hydration for the home to meet the hydration needs of residents.

i. The licensee's policy, 'Resident Hydration' did not define what specifies poor fluid intake nor did it include specific requirements for when a staff member would need to complete a referral. The policy directed staff, "If you feel a resident is not drinking close to [1,500 millilitres (ml)] on a daily intake, be sure to notify the RN as soon as possible"; however, the policy did not direct staff on how to determine if the resident's intake was less than 1,500 ml. Additionally, if the RN was notified, there was no direction for registered staff on how to proceed with this information.

ii. The licensee's policy, 'Nutrition Referrals', did not include any mention of dehydration or hydration status in relation to sending an RD referral. The Point Click Care 'Nutrition Care Referral Form' included a checkbox for "poor fluid intake (less than recommended minimum beverage intake for 3 consecutive days"; however, this was not included in any of the nutrition policies.

iii. According to resident #001's plan of care, they were at risk related to reduced fluid intake, with an individualized fluid goal per day.

The resident was sent to the hospital and returned on an identified date in July 2021, with a medical diagnosis. A referral was not sent to the RD for this, and interview with the RD confirmed that they did not assess the resident upon return from hospital.

Upon review of the resident's food and fluid intake records, from a specified time frame, except for one date, the resident's fluid intake was significantly below their fluid goal per day, even with the addition of an additional intervention. A referral was not made to the RD.

iv. According to resident #002's plan of care, they were at a high nutritional risk related to reduced fluid intake, with an individualized fluid goal per day.

Upon review of the resident's food and fluid intake records, from a specified time frame, the resident's fluid intake was below their fluid goal, even with the addition of any fluids brought in by the family. A referral was not made to the RD.

v. According to resident #003's plan of care, the resident was at risk with an individualized fluid goal per day.

The RD's most recent quarterly assessment of the resident indicated that the resident was below their individualized fluid goal, however, "Fluid intake may not include fluids from supplementation or provided at med pass". Record review confirmed that the resident did not have any dietary supplements ordered.

Upon review of the resident's food and fluid intake records from a specified time frame, the resident's fluid intake was below their fluid goal per day. A referral was not made to the RD.

The RD confirmed that the policies did not provide clear direction to staff regarding resident hydration and nutrition referrals, and subsequently, referrals were not sent for residents #001, #002 and #003 when they had poor fluid intake. By not providing clear direction to staff on when to make an RD referral for poor fluid intake, residents at risk were not assessed by the RD.

Sources: residents #001, #002, #003's clinical records, the home's policy 'Nutrition

Referrals' (dated January, 2018)' and 'Resident Hydration' (dated January, 2018) and interviews with RD and staff. [s. 11. (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 there was, an organized program of hydration for the home to meet the hydration needs of residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident, who exhibited altered skin integrity, received a skin assessment by a member of registered nursing staff upon any return of the resident from hospital.

The resident was sent to the hospital on two occasions and clinical record review confirmed that on both occasions a skin assessment was not completed and this was confirmed with the ADOC.

The risk of not completing an assessment when the resident returns from the hospital is not knowing if any areas of altered skin had worsened or if any new areas were acquired when the resident was away from the home.

Sources: resident's clinical record, the home's policy 'Skin/Wound Care' (No 03-1.2, last reviewed January 2021) and interview with the ADOC. [s. 50. (2) (a) (ii)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

The licensee's policy 'Skin/Wound Care' directed registered staff that upon discovery of altered skin integrity, a baseline assessment using a clinically appropriate assessment instrument (weekly wound assessment) was to be completed.

On an identified date a progress note identified that the resident had new areas of altered skin integrity. A review of the home's weekly wound assessments/observations did not include a wound assessment related to the finding of altered skin integrity. RPN #113 confirmed that when resident #001's altered skin integrity was identified, they did not use a clinically appropriate assessment tool.

By registered staff not completing a skin assessment with a clinically appropriate instrument, the resident was at risk for an inconsistent process in the treatment and promotion of skin integrity.

Sources: resident's electronic record, the home's policy 'Skin/Wound Care' (No 03-1.2; last reviewed January 2021) and interview with RPN #113. [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that a resident exhibiting altered skin integrity was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the residents plan of care relating to nutrition and hydration were implemented.

The licensee's policy 'Skin/Wound Care' directed registered staff to send a referral to the RD when identifying residents at risk for altered skin integrity.

i. On an identified date in June 2021, the resident progress note identified that they had new areas of alteration in skin integrity. A review of the resident's clinical record did not include an RD assessment or a nutritional referral and this was confirmed by the RD and RPN #113.
ii. On an identified date in August 2021, the resident's progress note identified new areas

of altered skin integrity to a specified area. A review of the resident's clinical record did not include an RD assessment or a nutritional referral related to the new areas of altered skin integrity and this was confirmed by the RD.

The resident was at risk for inadequate nutrition related to their new skin integrity issues, when the RD did not reassess the resident care needs.

Sources: resident's electronic record, the home's policy 'Skin/Wound Care' (No 03-1.2; last reviewed January 2021) and interview with RD and staff. [s. 50. (2) (b) (iii)]

4. The licensee has failed to ensure that a resident, who exhibited altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff, when clinically indicated.

The home's policy 'Skin/Wound Care' directed registered staff to complete the weekly wound assessment tool and assess wounds weekly.

The resident had areas of altered skin to specified areas. A review of the clinical record identified that weekly wound assessments were not completed weekly.

RPN #109 confirmed that they did not complete the weekly wound assessments that were due on two occasions in August 2021.

The risk of not completing weekly wound assessments for the resident was that staff could not evaluate if the wounds were worsening as there were no weekly assessments to compare to.

Sources: skin and wound assessments of the resident, interview with RPN #109 and the home's policy 'Skin/Wound Care' (No 03-1.2, last reviewed January 2021). [s. 50. (2) (b) (iv)]

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 returns from the hospital a skin assessment is completed, when a resident has areas of altered skin integrity an assessment is completed using a clinically appropriate assessment and a referral to the RD is made and weekly skin and wound assessments are conducted, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

The point of care (POC) documentation was reviewed from a specified time in July until a specified date in August 2021 and there was no documentation that the resident had their bath twice per week. Interview with PSW #114 and #115 confirmed that they did provide the baths but were not aware that they were to continue to document that the resident received bed baths two times per week in the POC documentation under the bathing tab.

Sources: resident's clinical record, the home's bathing records and interview with staff. [s. 30. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

The licensee has failed to ensure that procedures were implemented for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids, in accordance with manufacturer’s specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

An observation of resident #004's wheelchair on two dates in September 2021, identified their wheelchair was dirty.

The home's policy stated that wheelchairs are cleaned monthly on nights or as necessary. It was identified that the wheelchair was cleaned as per the cleaning schedule earlier in the month; however, was not cleaned as necessary. The ADOC confirmed that the wheelchair should have been cleaned as necessary when the wheelchair was observed dirty.

Sources: observation of resident #004's wheelchair, cleaning schedule, the home's policy Cleaning of Nursing Equipment (No 07-1.1, last reviewed November 2020) and interview with ADOC. [s. 87. (2) (b)]

WN #7: 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. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

The licensee failed to ensure that a hand hygiene program was in place in accordance with the Ontario evidence based hand hygiene program, "Just Clean Your Hands" related to staff assisting residents with hand hygiene before and after snacks.

On an identified date in September 2021, during the nourishment snack pass three residents were observed to be served and or assisted with a beverage without immediate prior assistance with hand hygiene.

Interviews with PSW #104 and #105 confirmed that assistance with resident hand hygiene was not completed prior to the distribution of beverages as they were unaware of this expectation.

The home's hand hygiene procedure, referred to staff hand hygiene and not resident hand hygiene and the Administrator confirmed that the home did not have a written program for resident hand hygiene.

The "Just Clean Your Hands" program requires that staff assist residents to clean their hands before and after snacks.

Failure to have a hand hygiene program in place in accordance with evidenced based practices presented a minimal risk to residents related to the possible ingestion of disease-causing organisms that may have been on their hands.

Sources: Observations of residents during the nourishment pass, interviews with PSWs and Administrator and review of the home's hand hygiene procedure and Just Clean Your Hands program resources. [s. 229. (9)]

Issued on this 8th day of October, 2021

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

Original report signed by the inspector.