Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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Original Public Report

Report Issue Date: February 6, 2023

Inspection Number: 2022-1554-0001

Inspection Type:
Complaint
Critical Incident System

Licensee: The Corporation of Haldimand County

Long Term Care Home and City: Grandview Lodge / Dunnville, Dunnville

Lead Inspector	**Inspector Digital Signature**
Pauline Waldon (741071)	Pauline Louise Waldon Digitally signed by Pauline Louise Waldon Date: 2023.02.13 11:30:38 -05'00'

Additional Inspector(s)
Yvonne Walton (169)
Olive Nenzeko (C205)
Carol Polcz (156)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):

November 18, 21-25, 28-30, December 2, 5-9, 12-14, 16, 19-20 2022 with December 20, 2022, conducted off-site.

The following intake(s) were inspected:

- Intake: #00004699 - Complaint regarding alleged neglect.
- Intake: #00005011 - Complaint regarding plan of care.
- Intake: #00006136 - Complaint regarding nutritional care.
- Intake: #00011306 - CIS# M532-000014-22 - Regarding falls prevention and management.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Resident Care and Support Services
Skin and Wound Prevention and Management
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management
Safe and Secure Home
Food, Nutrition and Hydration
Medication Management
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Emergency Services

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (4) 1. ix.

Rationale and Summary:
The home experienced a power outage on November 21, 2022, at 1431 hours and the emergency generator failed to work. They were without power for approximately 30 minutes. During that time specific residents that were on air beds, receiving oxygen, receiving enteral feeds, would be at risk as these services ceased to function. Residents that were in older style beds that did not have a foam core would be laying on the bed deck. Residents that were on oxygen concentrators would not receive oxygen and would need to be transferred to portable tanks. Residents receiving enteral feeds through the pumps would still have battery backup for a couple of hours. Interview with staff revealed they were unaware of these risks and had not received training as part of the annual emergency services training.

The maintenance supervisor and Director of Care confirmed these items were not included in the annual emergency services training.

Documentation also confirmed these are not included in the annual training.

Sources: Annual training records, interview with maintenance supervisor and Director of Care.

[169]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

Rationale and Summary:
A resident had a health condition requiring specified interventions to monitor the condition. Test results on two occasions over a month period, indicated the resident's levels were elevated and required monitoring.

a) The physician stated they should have monitored the elevated levels which in turn, would monitor the resident's health condition and confirmed that they did not do this.

b) The Registered Dietitian (RD) completed their assessment after the initial tests but did not review the test results as part of their assessment. The RD, in an email provided by the Administrator, confirmed that no assessment of the resident's health condition occurred. The resident was assessed by the RD on five subsequent occasions over a ten-week period, and there was no assessment of the resident's identified health condition or test results on any of these dates.

The clinical notes confirmed no monitoring of the initial test results. The physician and the RD did not collaborate their assessments related to the management of the resident's health condition resulting in a lack of follow up of the resident's elevated test results. The RD confirmed they did not look at the test results during their assessment and integrate them into the development of the plan of care. The physician confirmed they did not order follow up tests. The resident's plan of care was developed based on inconsistent assessments by the RD and the physician. Three days after the last RD assessment, the resident suffered a significant change in heath condition and elevated test results for their existing health condition. The clinical notes confirmed no follow-up tests were ordered to monitor the resident's

specified health condition.

Sources: Clinical record for resident, documentation of email from Registered Dietician to Administrator, interview with attending physician.

[156]

WRITTEN NOTIFICATION: Weight changes

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 75 1.

The licensee failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated, where there is a change of 5% or more of body weight over one month.

Rationale and Summary:
A resident with a weight change of 5.6% over one month, was not assessed by the Registered Dietician, as confirmed during an interview with dietary staff.

Sources: Clinical record for the resident and interview with dietary staff.

[156]

WRITTEN NOTIFICATION: Weight changes

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 75 2.

The licensee failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated, where there is a change of 7.5% or more of body weight over three months.

Rationale and Summary:

A resident had a weight change of 8.6% over a three-month period and a weight change of 10.4% over a four-month period, and was not assessed by the Registered Dietician, as confirmed during an interview with dietary staff.

Sources: Clinical record for the resident and interview with dietary staff.

[156]

WRITTEN NOTIFICATION: Menu Planning

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (1) (e)

The licensee failed to ensure that the homes menu cycle included a choice of other available entrees and side dishes at all three meals and a choice of other desserts at lunch and dinner to meet resident's specific needs or food preferences.

Rationale and Summary:
On November 29, 2022, during a tour of the kitchen, dietary staff confirmed that a resident was not provided with a choice of entrees, side dishes or desserts at lunch and dinner to meet the resident's specific needs or food preferences for a period of approximately two months in 2022.

Sources: Clinical record for the resident and interview with dietary staff.

[156]

WRITTEN NOTIFICATION: Registered Dietitian

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 80 (2)

The licensee failed to ensure that a Registered Dietician (RD) who was a member of the staff of the home was on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutritional care duties.

Rationale and Summary:
The home had contracted services for a RD who was on site to carry out clinical and nutritional care duties for 26 of the required 192 hours over three months. The remainder of the required hours were performed remotely and therefore, the home did not have a RD who was a member of the staff of the home on site for 166 out of 192 (86% of the time) required on site hours from September 1-November 30, 2022.

Sources: Documentation of email from contracted services to Administrator and interview with Administrator.

[156]

WRITTEN NOTIFICATION: Plan of Care Not Reviewed and Revised

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The Licensee has failed to ensure that resident #003 and #004 were reassessed and the plan of care reviewed and revised when the residents' care needs changed, or care set out in the plan was no longer necessary.

Rationale and Summary:
A) Resident #003 was injured during a fall resulting in a change in the resident's needs. The resident's plan of care was not updated to reflect their change in needs which was confirmed by the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator.

The home's failure to review and revise the resident's plan of care when the resident's needs changed, may pose a risk to the resident, as staff would not be aware of the resident's care needs.

Sources: Resident #003's clinical records, interview with RAI-MDS Coordinator.

[C205]

B) Resident #004's plan of care stated that only one drink be placed on the table at meals at a time, and

the resident was to use an assistive device for drinking. The plan of care did not include the use of a regular cup. In addition, the plan of care had a specified daily fluid goal.

The resident was observed with three drinks on the table at mealtime. Dietary staff confirmed that the plan of care was not being followed because the resident was not drinking well with one choice, and the plan of care should be updated.

The resident was observed to be given drinks from a regular cup by registered and Personal Support Worker (PSW) staff. PSW staff confirmed the regular cup is used although it is not included in the plan of care. The registered staff confirmed the regular cup is used when providing nutritional supplements and should be included in the plan of care.

The resident had a physician order for two litres of water per day. Registered staff and the Director of Nursing (DON) confirmed that the resident's plan of care did not include this change and should have been updated.

Failure to revise the residents plan of care, may put the resident at risk for swallowing concerns and impact the resident's hydration status.

Sources: Observations, resident #004's care plan, Digital Prescriber's Orders, interviews with dietary staff, registered staff, PSW and DON.

[741071]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The Licensee has failed to ensure that a resident wounds were reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary:
The residents written plan of care identified that they had two wound areas. The Treatment Administration Record (TAR) indicated that Weekly Wound Assessments were to be done for the

wounds but were not completed as required. Over five months, assessments for one wound were not completed for a two-week period, and not completed for a 12-week period for the second wound. Measurements of both wounds showed an increase in size during this time.

Registered staff confirmed that the weekly wound assessments were not completed, but should have been done.

There was a risk that any change in the condition of the resident wounds, including any deterioration, would go unnoticed and no interventions would be put in place because the home failed to ensure that weekly wound assessments by registered staff were completed.

Sources: The resident's clinical records, interview with registered staff.

[C205]

WRITTEN NOTIFICATION: Pain Management

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

The licensee failed to ensure that when a resident was in pain, that their pain was assessed using a clinically appropriate assessment instrument specifically designed for pain.

Rationale and Summary:
Documentation identified that the resident experienced signs and symptoms of pain in relation to their wounds. On these documented occasions, the resident’s pain was not assessed, and the resident did not receive any additional interventions to manage the increase in pain beyond their regularly scheduled pain medication. The Quality Assurance Nurse reported that when a resident’s pain is not relieved by initial interventions, the expectation for registered staff is to complete a pain assessment.

By failing to complete an assessment of the resident’s pain using a clinically appropriate assessment tool, there is risk that the resident’s pain was not treated accordingly, impacting the management of the resident’s pain.

Sources: Interview with the Quality Assurance Nurse, resident’s progress notes, Medication

Administration Records, Treatment Administration Records and PAINAD assessments.

[741071]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure the implementation of any standard, or protocol issued by the Director with respect to infection prevention and control.

A. Section 9.1 (b) of the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes states, the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include hand hygiene, including, but not limited to, the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

The licensee has failed to ensure that staff completed the four moments of hand hygiene.

Rationale and Summary:
During snack service in one of the common areas, a staff member was observed delivering a drink to a resident, then preparing a yogurt for a second resident and assisting that resident by feeding them yogurt and adjusting the resident's blanket and chair. The staff member then touched the chair of a third resident, before lifting the lid off a juice container on the snack cart, without performing hand hygiene. On the same date, snack service was observed in another common area. A resident was observed touching a staff's hand, then the staff member gave another resident a drink without performing hand hygiene. A staff member was observed to touch a resident, then prepare that resident and two other residents' drinks without performing hand hygiene. The same staff member was observed to rub a resident's back, then administer cookies from a bag with their hand to seven residents without performing hand hygiene.

The Infection Prevention and Control (IPAC) Coordinator, confirmed that staff were not following the four moments of hand hygiene.

The failure of staff to follow the four moments of hand hygiene, puts residents and staff at risk for the transmission of disease-causing or infectious organisms.

Sources: Observations, interview with the IPAC Coordinator, IPAC Standard for Long-Term Care Homes (April 2022).

B. Section 10.1 of the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes states, the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). These agents shall be easily accessible at both point-of care and in other resident and common areas, and any staff providing direct resident care must have immediate access to 70-90% ABHR.

The licensee failed to ensure that hand hygiene products, specifically alcohol-based hand rub, and cleaning supplies in use in the home were not expired.

Rationale and Summary:
On November 18, 2022, on one home area, expired PreEmpt wipes were found on a PPE cart outside a resident's room and the alcohol-based hand rub inside another resident's room had expired on September 2022. In another home area, the alcohol-based hand rub located on the nurse's station desk had an expiry date of September 2022, the alcohol-based hand rub located at the resident common area sink, had an expiry date of 2021 and the alcohol-based hand rub located on the PPE cart outside a resident's room, had an expiry date of September 2022. In another home area, the alcohol-based hand rub inside a resident's room, had an expiry date of September 2021 and the Maxi Move lift had Accel Prevention wipes, that were attached via zip ties, with an expiry date of September 5, 2022.

Staff in the home acknowledged that the alcohol-based hand rub and wipes in two home areas, were expired. The Infection Prevention and Control (IPAC) Coordinator acknowledged that alcohol-based hand rub with an expiry date of September 2022 was in use in the home.

The failure to ensure the alcohol-based hand rub and cleaning supplies in use in the home were not expired, increased the potential for ineffective hand hygiene and cleaning/sanitizing therefore, increasing the risk of disease transmission.

Sources: Observations and interviews with staff and the IPAC Coordinator.

C. Section 10.4 (h) and (i), of the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes states the hand hygiene program shall include policies and procedures to support residents to

perform hand hygiene prior to receiving meals and snacks, and after toileting; and support for residents who have difficulty completing hand hygiene due to mobility, cognitive or other impairments.

The licensee has failed to ensure the home's hand hygiene program includes a process for staff to support residents with hand hygiene.

Rationale and Summary:
The Infection Prevention and Control (IPAC) Coordinator, reported that the hand hygiene policy stated that residents are encouraged to perform hand hygiene. They also reported that staff are to encourage residents when feasible and when they cannot, to follow the four moments of hand hygiene. Upon review of the policy, the IPAC Coordinator confirmed that resident hand hygiene was not included in the homes hand hygiene policy. The Director of Nursing (DON) confirmed that resident hand hygiene is not included in the staff training.

Failure to have a hand hygiene program in place to support resident hand hygiene in accordance with the IPAC Standard, increases the risk resident hand hygiene will not be supported, therefore increasing the risk of transmitting disease-causing or infectious organisms.

Sources: Interviews with the IPAC Coordinator and DON, IPAC Standard for Long-Term Care Homes (April 2022), Hand Hygiene policy C-45.1.1 last revised March 2022, Infection Control-Orientation 2022, Outbreak Management Annual Training 2022, and Infection Control Training Follow-up 2022.

[741071]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)

The licensee failed to ensure that when a resident presented with a temperature, that resident was assessed, and immediate action was taken.

Rationale and Summary:
A resident's temperature recordings on two separate occasions were 37.9 and 38.4 degrees Celsius and there was no documented assessment of the resident's signs and symptoms.

The Director of Nursing (DON) reported that if a resident presented with a temperature of 37.8 degrees Celsius, the registered staff are to assess the resident further and this assessment should be documented in a progress note. The DON confirmed that an assessment of the resident should have been documented.

The failure to assess and take immediate action when a resident presents with signs and symptoms of infection places the resident at risk for undetected illness and increases the risk for disease transmission.

Sources: Resident's temperature record and progress notes, interview with the DON.

[741071]

WRITTEN NOTIFICATION: Directives by Minister

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

Non-compliance with LTCHA s. 174.1 (3) and FLTCA, 2021 s. 184 (3)

The Licensee has failed to ensure that where the Act required the Licensee of a long-term care home to carry out every Minister's Directive that applies to the long-term care home, the Minister's Directive was complied with.

In accordance with the Minister's Directive: Coronavirus Disease 2019 (COVID-19) Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007 Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7, and with the Minister's Directive: COVID-19 response measures for long-term care homes, the licensee must complete Infection Prevention and Control (IPAC) audits every two weeks unless in outbreak and when a home is in outbreak, IPAC audits must be completed weekly.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 174.1 (3) of the LTCHA. Non-compliance with the

applicable requirement also occurred after April 11, 2022, which falls under s. 184 (3) of the FLTCA.

Rationale and Summary:
The home was in Covid-19 outbreak from January 12 to February 17, 2022. Infection Prevention and Control (IPAC) self-audits were only completed for three of the five weeks the home was in outbreak. The home was also in Covid-19 outbreak from July 26 to August 17, 2022, and IPAC self-audits were not completed during this time. In addition, IPAC self-audits were not completed every two weeks for June and July 2022, when the home was not in outbreak.

The IPAC Coordinator and Director of Nursing (DON) confirmed that IPAC self-audits were not completed at the required intervals.

Failure to complete IPAC self-audits at the required intervals, may increase the homes risk of outbreak and/or the ability to identify factors to manage an outbreak.

Sources: Interviews with IPAC Coordinator and DON, IPAC self-audits for January through November 2022, CIS# M532-000001-22, CIS# M532-000008-22.

[741071]

WRITTEN NOTIFICATION: Training and Orientation

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (a)

The licensee has failed to ensure that staff received training in hand hygiene.

Rationale and Summary:
Training records provided for two Personal Support Worker (PSW) staff indicated they had not received training in hand hygiene since 2019, which was confirmed by the Director of Nursing (DON).

Failing to educate the staff in proper hand hygiene increases the risk that proper hand hygiene will not be performed, putting residents and staff at risk for infection.

Sources: Interview/email with the DON, staff training records.

[741071]