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

Hamilton District
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Original Public Report

Report Issue Date: June 16, 2023	
Inspection Number: 2023-1554-0002	
Inspection Type: Critical Incident System	
Licensee: The Corporation of Haldimand County	
Long Term Care Home and City: Grandview Lodge / Dunnville, Dunnville	
Lead Inspector Nishy Francis (740873)	**Inspector Digital Signature** Nishy Francis Digitally signed by Nishy Francis Date: 2023.06.21 13:12:51 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 23, 25, 26, 29-31, and June 1, 2023

The following intake(s) were inspected:

- Intake #00002380/CI: M532-000004-22, intake #00003578/CI: M532-000007-22, intake #00017409 - M532-000001-23 and intake #00087016/CI: M532-000006-23 related to falls prevention and management
- Intake #00087644/CI: M532-000007-23 related to resident to resident abuse.

The following intake(s) were completed:

- Intake #00001796/CI: M532-000003-22, intake #00003533/CI: M532-000010-22, intake #00011296/CI:M532-000013-22, intake #00012000/CI: M532-000015-22, intake #00016944/CI: M532-000016-22, intake #00017492/CI: M532-000003-23 and intake #00002146/CI: M532-000006-22 related to falls prevention and management

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24(1)

The licensee has failed to ensure that a resident was protected from physical abuse.

Ontario Regulation 246/22 s. 2 (1)(c) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary
A resident was physically abused by another resident. A Registered Practical Nurse (RPN) intervened and separated the residents.

The aggressing resident was assessed to have moderate cognitive impairment and had a history of physical aggression towards staff and visitors as documented in their plan of care.

At the time of the inspection, co-residents remained at risk as the resident demonstrated physically responsive behaviours and steps were not taken to protect residents from the risk of altercations and potentially harmful interactions.

Sources: Interviews with staff; record review of the resident's clinical record. [740873]

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27(1)(a)(i)

The licensee has failed to ensure that a witnessed incident of abuse of a resident was immediately investigated.

Rationale and Summary:
A resident was physically abused by another resident. A RPN intervened and separated the residents. The home's policy on abuse investigations indicated that upon notification of allegation of abuse, the Director of Nursing (DON)/Administrator was to conduct an immediate and thorough internal investigation; interview potential witnesses, and gather documented signed statements.

A RPN acknowledged the home's management did not interview them following the incident. The DON confirmed the home's investigation process was not completed and should have been completed

immediately following the incident.

Sources: Interviews with staff; Resident Abuse Program Policy and Procedure number: A- 1.1, reviewed September 2022. [740873]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2)(b)(i)

The licensee has failed to ensure that when a resident exhibited altered skin integrity, they received 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.

Rationale and Summary

A resident was physically abused by another resident and sustained facial bruising from the altercation. Staff provided the resident immediate intervention for treatment. A RPN acknowledged a skin assessment was not completed for the resident using a clinically appropriate instrument. The DON confirmed the resident did not receive a skin assessment and they should have when they exhibited altered skin integrity.

Sources: Interviews with staff; record review of the resident's clinical record. [740873]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55(2)(b)(ii)

The licensee has failed to ensure that when a resident exhibited altered skin integrity, they received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection.

Rationale and Summary:

A resident returned to the home after hospitalization. A head-to-toe assessment was documented on a separate progress note by a member of the registered nursing staff. The staff documented altered skin integrity identified on the resident. Four days later, a personal support worker (PSW) asked a RPN to assess the resident for concerns of bruising. The RPN completed an assessment and documented old bruising that was not treated. The RPN acknowledged that bruising was not communicated during shift report. Documentation for that time period did not reference the altered skin integrity identified on the

resident.

The Quality Assurance (QA) nurse acknowledged the head-to-toe assessment of the resident identified altered skin integrity upon return from hospital. The QA nurse confirmed the altered skin integrity was not followed up with or treated until four days following return from the hospital.

Sources: Interviews with staff; record review of the resident's clinical record. [740873]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58(4)(c)

The licensee failed to ensure that when a resident demonstrated responsive behaviours, actions taken to respond to the needs of the resident, including assessments, interventions and the resident's responses to interventions were documented.

In accordance with O. Reg 246/22 s. 11(1)(b) the licensee is required to ensure that staff initiated a Dementia Observational System (DOS) flowsheet when residents demonstrated repetitive responsive behaviour incidents.

Specifically, staff did not comply with the policy "Responsive Behavior Policy & Procedure", reviewed May 2023, which was included in the licensee's Responsive Behaviours Program.

Rationale and Summary:

A resident demonstrated physically responsive behaviour towards a staff member. A RPN indicated that a DOS flowsheet was not initiated. The Associate DON confirmed the DOS flowsheet should have been initiated immediately following the incident.

When assessments and interventions were not documented, there is risk that a resident's behaviours were not captured and analyzed in responsive behaviour meetings.

Sources: Interviews with staff; Responsive Behavior Policy & Procedure 11-1.1, reviewed May 2023, record review of the resident's clinical record. [740873]