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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: October 25, 2024
Inspection Number: 2024-1554-0003
Inspection Type: Proactive Compliance Inspection
Licensee: The Corporation of Haldimand County
Long Term Care Home and City: Grandview Lodge / Dunnville, Dunnville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 26-27 and October 1-4 and 7, 2024

The following intake(s) were inspected:

- Intake: #00127511 - Proactive Compliance Inspection (PCI)

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Residents' and Family Councils
Food, Nutrition and Hydration
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Quality Improvement

Residents' Rights and Choices
Pain Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that the written plan of care set out the planned care for a resident related to skin and wound care.

Rationale and Summary
A resident had areas of altered skin integrity.
The resident and skin and wound assessments identified that the areas had been in place for some time.
The care plan did not include a focus statement or interventions related to skin conditions.
The care plan was revised to include the areas of altered skin integrity and

interventions.

Sources: A review of the care plan, treatment administration records and skin and wound assessments; resident observations and staff interviews.

Date Remedy Implemented: October 2, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for a resident set out the planned care for the resident, related to nutrition interventions.

Rationale and Summary
A resident's written plan of care included a specific nutrition intervention. The Kardex, which was the document referred to by the dietary staff, did not indicate the intervention. The resident was observed at meal service, and the nutrition intervention was not in place. Staff reported they were not aware of the intervention.

The resident's care plan and kardex were updated to indicate the appropriate intervention.

Sources: A resident's care plan and kardex; resident observations and staff interviews.

Date Remedy Implemented: September 27, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

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

Rationale and Summary
A resident had areas of altered skin integrity as identified in their skin and wound assessments.
The Minimum Data Set (MDS) coding for the time period indicated under section M for Skin Condition and associated Resident Assessment Protocol (RAP) that the resident did not have any areas of altered skin integrity.
The assessments were not consistent and did not complement each other related to the resident's skin condition.
The MDS coding and associated RAP was revised to support the areas of altered skin integrity in place at the time of the assessments.

Sources: Review of MDS coding and RAP; skin and wound assessments and treatment administration records and staff interviews.

Date Remedy Implemented: October 2, 2024

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that the written plan of care was revised when a resident had a change in care needs, related to continence care.

Rationale and Summary
An intervention was initiated for a resident related to continence, which was a change in care needs.
A review of the care plan did not include the use of the intervention.
The care plan was revised to include a focus statement related to the use of the intervention and other interventions to manage the change in care needs.

Sources: Review of progress notes and care plan for a resident; observations of the resident and staff interviews.

Date Remedy Implemented: October 2, 2024

NC #005 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,

(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee has failed to ensure that a resident who was incontinent, had an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on an assessment.

Rationale and Summary.
A resident was incontinent and required assistance with toileting. A continence assessment was completed for the resident, which indicated they were to be on a toileting program. Their written plan of care did not identify any interventions or directions for staff around toileting.

A staff member acknowledged that the resident's plan of care was not individualized based on the assessment that was completed. Their plan of care was updated to reflect their care needs.

Sources: A resident's clinical record; staff interviews.

Date Remedy Implemented: October 3, 2024

NC #006 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (2) 1.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
1. The name and position of the designated lead for the continuous quality improvement initiative.

The licensee has failed to ensure that their continuous quality improvement report, published on their website included the name and position of the designated lead for the continuous quality improvement initiative.

Rationale and Summary
The Grandview Lodge website was reviewed, and it included the Grandview Lodge annual report 2023. The report did not include the name and position of the designated lead for the continuous quality improvement initiative.

The report was updated to include the required information.

Sources: Review of the Grandview Lodge website including the annual report 2023; staff interviews.

Date Remedy Implemented: October 7, 2024

NC #007 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. i.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
i. the date the survey required under section 43 of the Act was taken during the fiscal year,

The licensee has failed to ensure that their continuous quality improvement report, published on their website included a written record of the date the resident and family/caregiver experience survey was taken during the fiscal year.

Rationale and Summary
The Grandview Lodge website was reviewed, and it included the Grandview Lodge annual report 2023. The report did not include the date the resident and family/caregiver experience survey was taken during the fiscal year.

The Administrator acknowledged that the information as required was not included in the published continuous quality improvement report, nor was the information located elsewhere on the website.

The required information was posted by the home.

Sources: Review of the Grandview Lodge website including the annual report 2023; staff interviews.

Date Remedy Implemented: October 7, 2024

NC #008 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. iii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that their continuous quality improvement report, published on their website included the dates when the results of the resident and

family/caregiver experience survey were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

Rationale and Summary
The Grandview Lodge website was reviewed, and it included the Grandview Lodge annual report 2023. The report did not include the dates when the results of the survey were communicated to the residents and their families, Residents' Council, Family Council and members of the staff of the home.

The Administrator acknowledged that the information as required was not included in the published continuous quality improvement report, nor was the information located elsewhere on the website.

The required information was posted by the home.

Sources: Review of the Grandview Lodge website including the annual report 2023; staff interviews.

Date Remedy Implemented: October 7, 2024

WRITTEN NOTIFICATION: Plan of care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that a resident's plan of care was based on an assessment of the resident and the needs of the resident related to strategies for safe feeding.

Rationale and Summary
A resident was at nutritional risk. They were assessed on two occasions and it was documented that several strategies for safe feeding were discussed with staff. The resident's written plan of care did not include all of the strategies for safe feeding that were documented in the assessment. Two staff members acknowledged that the strategies for safe feeding from the assessments should have been documented in the resident's plan of care.

There was potential for the resident to be at increased nutritional risk when the strategies for safe feeding were not included in their written plan of care.

Sources: A resident's clinical record; staff interviews.

WRITTEN NOTIFICATION: Plan of Care

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care set out in the plan of care related to bathing was documented for two residents.

Rationale and Summary

A) A resident's plan of care indicated that they were to have a bath twice weekly. There was no documentation that they had their scheduled bath on one occasion. Staff confirmed that the resident had their scheduled bath, but it was not documented.

B) The plan of care for a resident identified they were to be bathed twice a week. The Point of Care (POC) documentation did not include a record of any bathing activity on the resident's scheduled bath days on three occasions. Staff confirmed that bathing occurred on at least two of the three dates identified; however, due to an oversight was not documented.

Sources: Resident clinical records; staff interviews.

WRITTEN NOTIFICATION: Plan of care

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident was reassessed and their plan of care was revised when their care needs changed or care set out in the plan was no longer necessary.

Rationale and Summary
The care plan for a resident identified their level of assitance with toileting and a

related intervention.
Their plan for bladder continence identified the frequency of toileting, which did not align with the frequency documented under bowel continence.
The resident was not observed to be toileted according to the frequency documented in their plan of care.
Staff indicated the resident had a change in care needs and a new intervention was required.
Failure to ensure that the plan of care was revised with changes in care needs had the potential for the resident not to receive care as required.

Sources: Resident observations; review of the care plan and staff interviews.

WRITTEN NOTIFICATION: Windows

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents could not be opened more than 15 centimetres.

Rationale and Summary
On two occasions, five outdoor windows were identified which were accessible to residents and could be opened more than 15 centimetres.

Sources: Observations during the inspection and staff interviews.

WRITTEN NOTIFICATION: Air temperature

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The licensee has failed to ensure that the home was maintained at a minimum of 22 degrees Celsius.

Rationale and Summary
The home's Air Temperature Monitoring Logs included documentation of air temperatures below 22 degrees Celsius in various areas of the home on different dates and shifts, with temperatures as low as 19.5 degrees Celsius.
Failure to ensure that the home was maintained at a minimum temperature had the potential to impact residents' comfort.

Sources: Review of the home's Air Temperature Monitoring Logs and 24-Hour Charge Nurse Reports and staff interviews.

WRITTEN NOTIFICATION: Required Programs

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following

interdisciplinary programs are developed and implemented in the home:
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions.

The licensee has failed to ensure that their required interdisciplinary skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions was complied with.

Ontario Regulation 246/22 section 11 (1) (b) outlined that programs as required in the regulations were to be complied with.
The Skin and Wound Care Program required staff upon discovery of any alteration in skin integrity to initiate a Treatment Administration Record (TAR) order for weekly reassessments and an order for the wound care.

Rationale and Summary
A resident presented with an area of altered skin integrity.
The area, treatment order, nor reassessment requirements were included in the electronic TAR, as required in the program.
Failure to include an area of altered skin integrity, the treatment and need for reassessment on the TAR had the potential for staff to be unaware of the area, to be inconsistent with the treatment provided or for reassessments to not be completed.

Sources: Review of skin and wound assessments, progress notes and TAR; review of the Skin and Wound Care Program, and staff interviews.

WRITTEN NOTIFICATION: Menu planning

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (2) (b)
Menu planning
s. 77 (2) The licensee shall ensure that, prior to being in effect, each menu cycle,
(b) is evaluated by, at a minimum, the nutrition manager and registered dietitian who are members of the staff of the home; and

The licensee has failed to ensure that prior to being in effect, each menu cycle was evaluated by the Registered Dietitian (RD).

Rationale and Summary
The Supervisor of Dietary Services reported that the home's summer menu was not evaluated by the RD prior to being in effect.

Sources: Home-Level Menu Approval Tool; email records; staff interviews.

WRITTEN NOTIFICATION: Dining and snack service

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The licensee has failed to ensure that a resident was provided with an eating aid required to safely drink as comfortably as possible.

Rationale and Summary
A resident was at nutritional risk. Their Kardex, which was the document referred to by the dietary staff during meal service, indicated that they were to have an eating aid at meals.

The resident was observed and they were not provided the eating aid. A staff member acknowledged that the resident should have been provided with the eating aid to assist them to safely drink as comfortably as possible.

Sources: A resident's Kardex; resident observations and staff interviews.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the IPAC Standard for Long-Term Care Homes, with a revised date of September 2023, was implemented.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that Additional Precautions were to be followed in the IPAC program which included (f) additional personal protective equipment (PPE) requirements including appropriate

selection and application.

A resident had a sign on their door which identified they were on additional precautions and required PPE for personal care.
Staff were not observed wearing the required PPE during the provision of personal care for the resident.
Failure to use PPE as required had the potential to spread infections to other residents.

Sources: Review of plan of care, door signage and PPE for a resident; observations of staff and interviews.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (10)
Infection prevention and control program
s. 102 (10) The licensee shall ensure that the information gathered under subsection (9) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 246/22, s. 102 (10).

The licensee has failed to ensure that the information gathered under subsection (9) was reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

Rationale and Summary
A resident presented with an infection and a medication was prescribed.

The infection was not recorded on the home area Monthly Infection Report nor on the Monthly Infection Control Stats record. These documents were used for the collection of stats and the detection of trends.
Failure to include the infection in the required records resulted in inaccurate stats related to infections and had the potential to influence decision making related to reducing the incidence of infections.

Sources: Review of progress notes and Medication Administration Records for a resident; Monthly Infection Report; Monthly Infection Control Stats and staff interviews.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (15) 2.
Infection prevention and control program
s. 102 (15) Subject to subsection (16), every licensee of a long-term care home shall ensure that the infection prevention and control lead designated under this section works regularly in that position on site at the home for the following amount of time per week:
2. In a home with a licensed bed capacity of more than 69 beds but less than 200 beds, at least 26.25 hours per week.

The licensee has failed to ensure that the designated infection prevention and control (IPAC) lead worked in that position at least 26.25 hours per week.

Rationale and Summary
Grandview Lodge had a licensed capacity of 128 beds and required an IPAC lead,

designated to the position, to work onsite in the home for 26.25 hours a week.
The former IPAC lead left their position. A staff member was assigned the position of temporary IPAC lead for a period of time.
The staff member's tasks from their other role within the home were not redistributed in whole or part while they were assigned the position of temporary IPAC lead.
Failure to ensure that an IPAC lead worked the minimum number of hours in that position had the potential for IPAC responsibilities or activities to not be completed.

Sources: Review of IPAC lead job posting and staff interviews.

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Rationale and Summary

An outbreak of a disease of public health significance was declared in the home by Public Health.
The following day, the Service Ontario After-Hours Line was notified of the outbreak by staff at the home.

Sources: Review of a Info-Line and Critical Incident System Report, and staff interviews.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (b)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider. O. Reg. 66/23, s. 30.

The licensee has failed to ensure that a medication incident which involved a resident was reported to the Medical Director/Attending Physician.

Rationale and Summary
A resident was involved in a medication incident.

The incident was not reported to the Medical Director/Attending Physician. Failure to notify the Medical Director/Attending Physician when a medication incident was initially identified had the potential for desired timely assessments or interventions to not be ordered/completed.

Sources: Review of progress notes and medication incident report for a resident and staff interviews.

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2)
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
1. The home's Administrator.
2. The home's Director of Nursing and Personal Care.
3. The home's Medical Director.
4. Every designated lead of the home.
5. The home's registered dietitian.
6. The home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider.
7. At least one employee of the licensee who is a member of the regular nursing staff of the home.
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.
9. One member of the home's Residents' Council.

10. One member of the home's Family Council, if any.

The licensee has failed to ensure that the continuous quality improvement committee was composed of the required members.

Rationale and Summary
The home's Medical Director, Registered Dietitian, pharmacy service provider, one member of the home's Residents' Council and one member of the home's Family Council were not members of the continuous quality improvement committee as required.

Sources: CQI meeting minutes; staff interviews.

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (3)
Continuous quality improvement initiative report
s. 168 (3) The licensee shall ensure that a copy of the report is provided to the Residents' Council and Family Council, if any.

The licensee has failed to ensure that a copy of the continuous quality improvement report was provided to the Residents' Council.

Rationale and Summary
The Residents' Council meeting minutes were reviewed and there was no documentation that a copy of the continuous quality improvement report was provided to the Residents' Council.

Sources: Residents' Council meeting minutes; staff interviews.