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: December 4, 2024
Inspection Number: 2024-1554-0004
Inspection Type: Critical Incident
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): November 19-22 & 25-28, 2024.

The following intakes were inspected:

- Intake: #00116317 - Critical Incident (CI) #M532-000015-24 - related to prevention of abuse and neglect.
- Intake: #00121250 - CI #M532-000023-24 - related to falls prevention and management.
- Intake: #00125982 - CI #M532-000031-24 - related to prevention of abuse and neglect.
- Intake: #00130002 - CI #M532-000036-24 - related to resident care and support services.
- Intake: #00130514 -CI #M532-000039-24 - related to prevention of abuse and neglect.

The following intakes were completed:

- Intake #00117587 - CI #M532-000020-24 - related to falls prevention and management.
- Intake: #00124630 - CI #M532-000030-24 - related to falls prevention and management.

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights: Right to freedom from abuse and neglect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 5.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
5. Every resident has the right to freedom from neglect by the licensee and staff.

The licensee has failed to ensure that a resident's right to freedom from neglect by the licensee and staff was fully respected and promoted.

Rationale and Summary
After an incident with a resident, an investigation determined that a staff member falsified documents relating to the resident's care.
The home determined that the resident's right to freedom from neglect was not fully respected and promoted, putting the resident's safety at risk.

Failure of the licensee to ensure that the resident's right to freedom from neglect was fully respected and promoted could have had a serious impact on their health and well-being.

Sources: Critical Incident (CI), home's investigation package, interview with Administrator.

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

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

Rationale and Summary
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.

On a day in May 2024, a resident was walking next to a co-resident when an incident happened causing the resident to fall, sustaining an injury. The Assistant Director of Care (ADOC) confirmed that this incident was considered abuse.

Failure to protect resident from physical abuse by co-resident placed the resident at risk of harm.

Sources: CI, resident's clinical records, interview with ADOC.