Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 29, 2013	2013_214146_0005	H-001150-12	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

BARBARA NAYKALYK-HUNT (146)

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): January 16, 17, 2013

This inspection was conducted concurrently with Complaint inspection H-00950-12 and CI inspection H-001579-12.

During the course of the inspection, the inspector(s) spoke with the administrator, Director of Care (DOC), registered staff, Personal Support Workers (PSW's) and residents.

During the course of the inspection, the inspector(s) toured the home and reviewed the health record of a specific resident.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee did not ensure that the SDM had been given the opportunity to participate fully in the development and implementation of the plan of care.
1. The home discontinued, on admission, 5 of 8 medications that resident 001 had been taking prior to admission and decreased the dose of another. According to the SDM and the health record, the SDM requested on 5 occasions in one month, that the resident's medications be re-started. The request was denied; the SDM's participation in the plan of care was effectively denied. This information is confirmed by the SDM, the record and the DOC.
2. On a specific date, the SDM visited resident 001 at 2 pm and enquired why the bed was low to the floor and restricting the resident's ability to get out of the bed to go to the bathroom. When the explanation of falls risk was presented, the SDM assured the nurse that there had never been a fall and the bed needed to be returned to normal position. This was not done as the record indicates on a later date that the bed was low to the floor on day shift. This was confirmed by the health record and the SDM.
3. The SDM voiced concern on a certain date, that resident 001 had an infection and requested a specimen be obtained. The SDM stated that the resident had been more confused and the urine was concentrated. The request was declined. The records indicate that the urine was foul smelling on 2 separate dates and concentrated on another date. The record also indicates the resident complained of groin pain on 2 dates. The record indicates that resident 001 was confused and later that same day a note stated that the resident was not his usual self. Another note indicated that resident 001 was lethargic. No specimen was obtained. This information was confirmed by the SDM, the health care record and the registered staff. [s. 6. (5)]

Issued on this 29th day of January, 2013

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

BARB NAYKALYK-HUNT