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
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 14, 2014	2014_248214_0023	H-000912-13	Critical Incident System

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

CATHY FEDIASH (214)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 13, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Quality Assurance Registered Practical Nurse (RPN).

During the course of the inspection, the inspector(s) reviewed clinical records, the critical incident report and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure that any plan, policy, protocol, procedure, strategy or system was complied with.

A review of the home's policy, Falls Prevention and Management Program (11-1.11 and dated January 2011), indicated that when a resident has fallen, Registered Nursing Staff are to:

- Complete the head to assessment
- Document in the progress notes: who was notified of the falls (e.g., physician, POA/SDM), probable cause of the fall, resident outcomes and interventions taken to prevent further falls or related injury

A review of resident #300's clinical record as well as the critical incident submitted by the home, indicated that on an identified date in December 2013, the resident sustained a fall with injury. A review of the resident's clinical record including their progress notes indicated that a head to assessment had not been completed following their fall and the probable cause of the fall and interventions taken to prevent further falls or related injury, had not been documented in their progress notes. An interview with the DON confirmed that the home's policy had not been complied with. [s. 8. (1) (b)]

Issued on this 14th day of August, 2014

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