

conformité

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care

Health System Accountability and Performance Division Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée

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	Licensee Copy/Copie du Titulai	re Public Copy/Copie Public
Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
January 12, 2011	2011_171_9532_12Jan102304	CIS – H-02517 H-03047 H-03078
Licensee/Titulaire		
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(s)		
Elisa Wilson, LTC Homes Inspector #171		
Inspection Summary/Sommaire d'inspection		
The purpose of this inspection was to conduct an inspection regarding three recent critical incidents related to resident care.		
During the course of the inspection, the inspector spoke with: the administrator, the director of nursing, registered staff and residents.		
The inspector reviewed plans of care for three residents and interviewed available staff that had been working on the dates of the critical incidents.		
The following Inspection Protocols were used during this inspection: Falls Prevention		
Findings of Non-Compliance were	found during this inspection.	The following action was taken:
4 WN		
1 VPC		



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NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN - Written Notifications/Avis écrit

VPC - Voluntary Plan of Correction/Plan de redressement volontaire

DR - Dîrector Referral/Régisseur envoyé

CO - Compliance Order/Ordres de conformité

WAO - Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le Loi de 2007 les foyers de soins de longue durée à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.3(1)2. Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

2. Every resident has the right to be protected from abuse.

Findings:

A resident reported to staff that the resident was abused. The resident was interviewed and was able
to confirm this incident happened. The Home did not ensure that this resident was protected from
abuse.

Additional Required Actions:

VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents are protected from abuse, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.3(1)4. Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

Findings:

1. The plan of care for a resident indicates a requirement for physical assistance to get on and off the commode. This resident was assisted by two personal support workers onto the commode at the bedside, however they did not return in a timely manner to assist the resident off the commode. The call bell was on the floor out of reach.



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WN #3: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8,s.24(1)2. A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Findings:

 An incident of abuse of a resident was not immediately reported to the Director. The Director (Ministry of Health and Long-Term Care) did not receive notification until three days after the incident took place.

WN #4: The Licensee has failed to comply with O.Reg. 79/10, s. 49(2). Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Findings:

A resident fell one morning in December 2010 and a progress note was completed at that time.
 However, an assessment using an instrument that is specifically designed for falls was not used after this fall.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
Title: Date:	Date of Report: (if different from date(s) of inspection). Jan 31 /201/