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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 21, 2017	2017_575214_0013	018046-17	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 4, 8, 9, 10, 14, 2017.

Please note: the following onsite inquiry was conducted with the Critical Incident System inspection: 007684-17 related to falls management.

During the course of the inspection, the inspector(s) spoke with the Administrator; the Director of Nursing (DON); the Nursing Quality Assurance lead. During the course of this inspection, the Inspector reviewed a Critical Incident System (CIS) submission; reviewed resident health care records; reviewed policies and procedures and observed residents.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (6) When a resident is admitted to a long-term care home, the licensee shall, within the times provided for in the regulations, ensure that the resident is assessed and an initial plan of care developed based on that assessment and on the assessment, reassessments and information provided by the placement co-ordinator under section 44. 2007, c. 8, s. 6 (6).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident was admitted to a long-term care home, that the resident was assessed and an initial plan of care developed based on that assessment and on the assessment, reassessments and information provided by the placement co-ordinator under section 44.

A review of progress notes and a CIS submitted by the home on an identified date, indicated that the home submitted the CIS in relation to an identified incident between two residents. The CIS indicated that resident #200 was observed to have come from behind resident #300's bedside curtain and leave their room. Staff responded to resident #300 and observed them sleeping in their bed in an identified manner. Registered staff assessed the resident and no injury had been identified. Increased monitoring of resident #200 was put into place.

The following day, front line nursing staff observed resident #200 enter resident #300's room and sit down beside resident #300. Staff observed resident #200 make an identified motion toward resident #300 and ask resident #300 a specified question. Documentation indicated that resident #300 pushed resident #200 away. Staff entered the resident's room at this time and redirected resident #200 out of the room.

A review of the CIS and an interview with the DON confirmed that resident #200 had a known history of an identified responsive behaviour, prior to admission to the home and that the resident had an identified activity of daily living (ADL) preference related to sleeping.

A review of resident #200's admission assessment Minimum Data Set (MDS) coding, that was dated on an identified date, indicated under the specified coding that the resident was coded as a zero (0) and that the specified behaviour had not been exhibited in the last seven days. A review of corresponding specified Resident Assessment Protocols (RAPS), indicated that these two RAPS had not been triggered for this assessment.

A review of identified admission paperwork, indicated that resident #200 had a history of identified responsive behaviours prior to their admission. A review of an identified assessment prior to admission, indicated that recent complaints were verbalized related to the resident's identified responsive behaviours. MDS coding under an identified section and a corresponding identified RAP that was completed by the placement co-ordinator and dated on an identified date, indicated that the resident was coded as demonstrating identified responsive behaviours. A review of an identified assessment

completed by the placement co-ordinator and dated on an identified date, indicated that the resident had a history of identified responsive behaviours.

A review of the resident's written plan of care in place since their admission to the home on an identified date, indicated that no initial plan of care had been developed and no plan was in place at the time of this inspection that included the resident's known history of responsive behaviours and no plan of care had been developed since admission to the home that included an identified ADL preference related to sleeping.

An interview with the Nursing Quality Assurance lead confirmed that the initial plan of care for resident #200 had not been developed and based on the assessments and information provided by the placement co-ordinator in relation to the resident's history of identified responsive behaviours and potential for injury to their self or others. [s. 6. (6)]

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 that when a resident is admitted to a long-term care home, the licensee shall ensure that the resident is assessed and an initial plan of care developed based on that assessment and on the assessment, reassessments and information provided by the placement co-ordinator under section 44, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was in place a written policy to promote zero

tolerance of abuse and neglect of residents and that the policy was complied with.

A review of progress notes and a CIS submitted by the home on an identified date, indicated that the home submitted the CIS in relation to an identified incident between two residents. The CIS indicated that resident #200 was observed to have come from behind resident #300's bedside curtain and leave their room. Staff responded to resident #300 and observed them sleeping in their bed in an identified manner. Registered staff assessed the resident and no injury had been identified. Increased monitoring of resident #200 was put into place.

The following day, front line nursing staff observed resident #200 enter resident #300's room and sit down beside resident #300. Staff observed resident #200 make an identified motion toward resident #300 and ask resident #300 a specified question. Documentation indicated that resident #300 pushed resident #200 away. Staff entered the resident's room at this time and redirected resident #200 out of the room.

A review of the home's policy, titled, "Abuse to Residents" (A-1 with a reviewed date of September 2016) indicated the following:

i) Under "Discovering or witnessing Resident Abuse": All staff, Residents, family members, students or volunteers who discover, witness or have reason to believe that Resident Abuse has taken place are required to immediately report this to the Home's Administrator or designate.

The home's Administrator or designate are responsible to:

1. Immediately call the MOHLTC (Ministry of Health and Long Term Care) at1-800-268-6060 to report, and
2. On the first business day, complete a Critical Incident Form to the MOHLTC.

Any person may report witnessed or suspected abuse to any of the following:

- The Administrator (or designate) of Grandview Lodge
- The Ministry of Health and Long-Term Care
- The toll free Long-Term Care ACTION LINE: 1-866-434-0144

Those who witness or have knowledge of abuse of a resident and fail to report it may appear to be colluding with the abuser or condoning the abuse. Under the Nursing

Homes Act, a person other than a resident who has reasonable grounds to suspect that a resident has suffered or may suffer abuse or neglect is required to report the suspicion and the information on which it is based to the MOHLTC; it is an offence to contravene this requirement.

An interview with the DON confirmed that the incident involving resident #200 on an identified date, had not been immediately reported to the Director at the MOHLTC until the following day, following the second incident involving this resident. The DON confirmed that the home had not complied with their written policy to promote zero tolerance of abuse of residents. [s. 20. (1)]

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 that there is in place a written policy to promote zero tolerance of abuse and neglect of residents and that the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A review of progress notes and a CIS submitted by the home on an identified date, indicated that the home submitted the CIS in relation to an identified incident between two residents. The CIS indicated that resident #200 was observed to have come from behind resident #300's bedside curtain and leave their room. Staff responded to resident #300 and observed them sleeping in their bed in an identified manner. Registered staff assessed the resident and no injury had been identified. Increased monitoring of resident #200 was put into place..

The following day, front line nursing staff observed resident #200 enter resident #300's room and sit down beside resident #300. Staff observed resident #200 make an identified motion toward resident #300 and ask resident #300 a specified question. Documentation indicated that resident #300 pushed resident #200 away. Staff entered the resident's room at this time and redirected resident #200 out of the room.

A review of resident #300's clinical record indicated that the incident that had occurred on an identified date, including actions taken by staff to assess resident #300 following this incident, had not been documented in resident #300's clinical record.

An interview with the Nursing Quality Assurance lead confirmed that actions taken, including assessments for resident #300, had not been documented in the resident's clinical record, following the first incident. [s. 30. (2)]

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 that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

Issued on this 6th day of September, 2017

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

Original report signed by the inspector.