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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: January 4, 2024

Inspection Number: 2023-1554-0005

Inspection Type:
Critical Incident
Follow up

Licensee: The Corporation of Haldimand County

Long Term Care Home and City: Grandview Lodge / Dunnville, Dunnville

Lead Inspector	**Inspector Digital Signature**
Stephanie Smith (740738)	Stephanie D Smith Digitally signed by Stephanie D Smith Date: 2024.01.17 15:01:59 -05'00'

Additional Inspector(s)
Kerry O'Connor (000769)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 14-15, and 18-22, 2023.

The following intake(s) were inspected:

- Intake: #00102692 - CI (Critical Incident): M532-000038-23 - Fall of resident.
- Intake: #00097367 - CI: M532-000024-23 - Related to sexual abuse.
- Intake: #00097505 - Follow-up #: 1 - Compliance Order (CO) #001/ 2023-1554-0004, O. Reg. 246/22 - s. 24 (3) Air temperature, CDD: November 29, 2023.

The following intake(s) were completed in this inspection:

- Intake: #00089940, CI: M532-000013-23; Intake: #00092618, CI: M532-000017-23; Intake: #00097604, CI: M532-000025-23; Intake: #00100571, CI: M532-000032-23; Intake: #00101649, CI: M532-000036-23 were all related to falls prevention and management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1554-0004 related to O. Reg. 246/22, s. 24 (3) inspected by Stephanie Smith (740738)

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

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

Plan of care

When reassessment, revision is required

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(b) the resident's care needs change or care set out in the plan is no longer necessary;

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs changed.

Rationale and Summary
A resident experienced three incidents of inappropriate touching from another resident on specified dates in August and September, 2023.

The resident's care plan was not updated with safety interventions until a specified date in October, 2023.

The Associate Director of Nursing (ADON) acknowledged that the care plan should have been updated after the first incident in August, to protect the resident from further incidents.

Failure to ensure that the resident's plan of care was reviewed and revised when their needs changed, put the resident at risk for harm.

Sources: Resident's clinical record, interview with ADON. [740738]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) 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.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

Rationale and Summary
The home submitted a Critical Incident (CI) report to the Ministry of Long-Term Care on a specified date in September, 2023, for an incident of alleged abuse that occurred four days prior. There was no call to the after hours reporting line regarding the incident.

Upon review of progress notes, the Administrator recognized that the incident should have been reported and completed a CI report at the time of the incident.

Failure to ensure that an incident of alleged abuse was immediately reported to the Director, put residents at risk of harm or abuse.

Sources: CI: M532-000024-23, interview with Administrator. [740738]

WRITTEN NOTIFICATION: General requirements

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections

11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee failed to ensure that the dates changes were made to the falls prevention and management program were included in the evaluation of the program.

Rationale and Summary
The falls prevention and management program was evaluated in September, 2023. New clip alarms were introduced and used by the home within twelve months prior to the evaluation date. The date the licensee began using the alarms were not included in the falls prevention and management program evaluation.

Failure to ensure the date new clip alarms began being used by the licensee were included in the falls prevention and management program evaluation did not cause any risk to the resident.

Sources: Falls committee yearly review, Interview with Quality Assurance (QA) nurse. [000769]

WRITTEN NOTIFICATION: Falls prevention and management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to comply with their Falls prevention and management policy for a resident when an intervention was not completed post fall.

In accordance with O. Reg., 246/22, s. 11 (1) (b), the licensee was required to ensure that there was a Falls prevention and management program that provided for monitoring of residents and must be complied with.

Specifically, staff did not comply with the policy "Falls prevention and Management", which was included in the licensee's Falls prevention and management program.

Rationale and Summary
On a specified date in November, 2023, a resident had an unwitnessed fall. Registered staff did not initiate an intervention.

The home's QA nurse acknowledged that the home's current practice differed from their policy and that they would need to consider changing their policy.

Failure to ensure that a resident received an intervention as per the home's Falls policy, put the resident at risk of unrecognized injury.

Sources: Falls prevention and management program policy, Physical chart for resident; Interviews with Registered staff, Falls lead, and QA nurse. [000769]

WRITTEN NOTIFICATION: Notification re incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (b)
Notification re incidents
s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Rationale and Summary
On a specified date in September, 2023, direct care staff witnessed a resident exhibiting inappropriate behaviours toward another resident. The incident was reported to the Registered Staff working at the time as well as to the ADON. Both the registered staff and ADON acknowledged the incident as potential abuse.

The resident's progress notes indicated that their SDM was not notified of the alleged abuse until four days after the incident.

The home's Administrator acknowledged that they informed the resident's SDM of the incident fours days after the incident occurred.

Failure to ensure that a resident's SDM was notified within 12 hours of any alleged, suspected or witnessed incident of abuse put the resident at risk of their SDM not being involved in the circle of care.

Sources: A resident's progress notes, interviews with Registered staff, ADON, and Administrator. [740738]

COMPLIANCE ORDER CO #001 Duty to protect

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

- Provide education to all registered staff regarding their duty to report alleged, witnessed, or suspected incidents of abuse to the Director, including education for submission of a Critical Incident (CI) report and/or utilizing the after-hours reporting line and;
- Create or amend the home's internal reporting and investigation processes regarding each discipline's responsibilities to ensure that all instances of abuse are reported and investigated as per the legislation and;
- Retain records of the education including: the content of the education, who attended, the date the education was provided, and who provided the education.

Grounds

The licensee has failed to ensure that a resident was protected from sexual abuse by another resident.

Section 2 of Ontario Regulation (O. Reg.) 246/22 defines sexual abuse as (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Rationale and Summary

On a specified date in September, 2023, direct care staff witnessed a resident exhibiting inappropriate behaviours toward another resident. The direct care staff separated the residents and informed Registered staff of the incident.

Upon the home's investigation, they determined that there were two prior similar incidents:

- On a specified date in August, 2023, a resident exhibited inappropriate behaviours toward another resident. Staff intervened and the Registered staff working at the time was informed of the incident.
- On another specified date in September, 2023, a resident exhibited inappropriate behaviours toward another resident. Registered staff documented the incident.

Furthermore, there was an additional incident on a specified date in November, 2023.

As a result of those incidents, interventions were implemented for the resident exhibiting inappropriate behaviours.

The other resident was cognitively impaired and unable to provide consent to the inappropriate behaviour.

The ADON acknowledged the incidents on specified dates in August and September, 2023.

Failure to protect a resident from sexual abuse by another resident, put the resident at risk for harm and abuse.

Sources: Resident's' clinical records, CI: M532-000024-23, interviews with Registered staff, direct care staff, and ADON. [740738]

This order must be complied with by February 9, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and

(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.

(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.