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

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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
Jan 8, 2014	2013_105130_0043	H-000792-13,H-000766-13	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

GILLIAN TRACEY (130), 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): December 16, 17, 18 and 19, 2013.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Manager of Recreation Services, Registered Staff, Resident Assessment Instrument (RAI) Coordinator, personal support workers, administrative staff, residents and families.

During the course of the inspection, the inspector(s) interviewed staff, residents and families, reviewed clinical records, relevant policies and procedures and observed care.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Dignity, Choice and Privacy
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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 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 did not ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

a) The home's policy Resident Abuse-Investigating And Reporting (A-1.2) indicated that all staff, residents, family members, students or volunteers who discovered, witnessed or had reason to believe that resident abuse had taken place were required to immediately report this to the home's Administrator or designate. Resident #002 was observed and documented by staff to have been involved in four incidents of sexual abuse toward co-residents in 2013. The licensee was only aware of three of the four incidents. It was noted that on all four occasions, registered staff took immediate actions and recorded the events in the clinical record. Registered staff did not report an incident on an identified date in 2013, to the Administrator or designate, as required by the home's policy. This information was verified by the DRC. [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 the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee did not ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

a) Resident #002 was admitted in 2013. On identified dates in 2013, documentation in the resident's clinical record identified episodes of responsive behaviours with staff and co-residents. There were no interventions identified in the resident's plan of care to manage these behaviours and minimize risks to other residents after potentially harmful incidents had occurred. This information was confirmed by registered staff. [s. 54. (b)]

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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) 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. 2007, c. 8, s. 3 (1).

s. 3. (1) 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. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that every resident was protected from abuse.

a) According to the clinical record, on at least four identified dates in 2013, resident #002, with known responsive behaviours, was observed to be engaged in inappropriate sexual interaction with non consenting co-residents, #003 and #004. This information was confirmed by the DRC and by documentation reviewed. [s. 3. (1) 2.]

2. The licensee did not ensure that the every resident was properly sheltered, fed, clothed, and cared for in a manner consistent with his or her needs.

a) On an identified date in 2013, a volunteer portered resident #005 to their home area from an activity, when it was suspected the resident required continence care. The plan of care indicated the resident was cognitively impaired and dependent on staff for assistance with continence care. According to the statement of the volunteer, the staff member who was alerted to the resident's care needs, refused to provide care because they were on break. The staff member did not seek help from a coworker to assist the resident. The resident was portered to an activity room, where they sat in their wheelchair and waited for staffs assistance. Staff interviewed were unable to confirm the time the resident's continence care needs were met. [s. 3. (1) 4.]

Issued on this 8th day of January, 2014

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