



**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**

Ottawa Service Area Office  
347 Preston St 4th Floor  
OTTAWA ON L1K 0E1  
Telephone: (613) 569-5602  
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa  
347 rue Preston 4<sup>ième</sup> étage  
OTTAWA ON L1K 0E1  
Téléphone: (613) 569-5602  
Télécopieur: (613) 569-9670

## Public Copy/Copie du public

<b>Report Date(s) / Date(s) du apport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Feb 20, 2015	2015_285546_0004	O-000329-14 X O- 001011-14 X O-001121 -14	Complaint

### Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF CORNWALL  
1900 Montreal Rd. CORNWALL ON K6H 7L1

### Long-Term Care Home/Foyer de soins de longue durée

GLEN-STOR-DUN LODGE  
1900 MONTREAL ROAD CORNWALL ON K6H 7L1

### Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SUSAN WENDT (546)

## Inspection Summary/Résumé de l'inspection



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des  
Soins de longue durée**

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

**Rapport d'inspection sous la  
Loi de 2007 sur les foyers de  
soins de longue durée**

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): January 12, 13, 14, 15, 16, 21, 22, 23, 26, 27, 2015**

**For the following logs:**

**O-000329-14**

**O-001011-14**

**O-001121-14**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, one registered practical nurse, Personal Support Workers.**

**In addition, the inspector reviewed complaints, reviewed identified residents' health records, observed resident care and services, reviewed the posted Residents' Bill of rights, reviewed investigative notes taken by the Home, reviewed the Home's Program for responsive behaviours.**

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

**Dignity, Choice and Privacy**

**Personal Support Services**

**Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**

**1 WN(s)**

**1 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**



**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 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:**

**11. Every resident has the right to,**

**i. participate fully in the development, implementation, review and revision of his or her plan of care,**

**ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**

**iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**

**iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**



1. The licensee has failed to ensure that the substitute decision-maker has access to the resident's records of personal health information (within the meaning of the Personal Health Information Protection Act, 2004), including the plan of care.

During a specific week in September 2014, the substitute decision-makers/attorneys for personal care (SDM) requested a complete copy of the resident's health record and plan of care (from July 2014 to present). The SDM was informed by the Administrator and the Director of Nursing (DON) that it was not possible for the SDM to obtain a copy but that they could view parts of it or could ask questions of the attending registered staff. The SDM proceeded in asking for the information; each time, the registered staff would only read out loud the sections requested by the family. In an interview with the family, the SDM confirmed that registered staff were informed that if anyone requested any information about the resident, they were to consult with the DON.

On a specific date in January 2015, in an interview with the inspector, when questioned about a specific resident, S#101 informed the inspector that for all information about this specific resident, the inspector was to consult with the DON.

In a discussion with the inspector on two specific dates in January 2015, the DON confirmed that no hard copy of the resident's health record and plan of care had been provided to the SDM, as per their request. [Log O-001121-14] [s. 3. (1) 11. iv.]

***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 substitute decision-makers/attorneys for personal care have access to the resident's records of personal health information, including the plan of care, to be implemented voluntarily.***

---



**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**

**Issued on this 6th day of March, 2015**

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

**Original report signed by the inspector.**