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 prévue le Loi de 2007 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 Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Oct 22, 2015;	2015_384161_0006 (A3)	O-001745-15	Resident Quality Inspection

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

Ontario

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KATHLEEN SMID (161) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee has requested an extension to the compliance date for the two Compliance Orders issued as a result of the Resident Quality Inspection conducted in April 2015. The compliance date for these orders was originally September 30, 2015 and was amended as per licensee request to November 30, 2015.

The licensee has provided a letter dated October 16, 2015 with an explanation of the factors that are delaying their ability to achieve full compliance by the compliance date of November 15, 2015. The compliance date for Compliance Order #001 and #002 are amended to reflect a new date of August 30, 2016.

The licensee will implement measures to ensure resident safety until such time as compliance is achieved with Compliance Order #001, specifically O. Reg. 79/10, s. 9 (1) 1. iii AND with Compliance Order #002 specifically O.Reg. 79/10, s.17,(1)(c).

Issued on this 22 day of October 2015 (A3)

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

Original report signed by the inspector.

Ontario

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

KATHLEEN SMID (161) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 16 - 20, 2015 and March 23 - 27, 2015.

During the course of the inspection, the inspector(s) conducted a tour of the Resident care areas, reviewed Residents' health care records, home policies and procedures, posted menus, observed Resident rooms, observed Resident common areas, reviewed Residents' Council and Family Council minutes, observed a medication pass, observed one meal service, and observed the delivery of Resident care and services.

During the course of the Resident Quality Inspection, the inspector(s) also conducted a complaint inspection log #O-001826-15.

During the course of the inspection, the inspector(s) spoke with Residents, Family Members, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Housekeepers, Kinesiologist, RAI MDS Coordinator, Staff Development/Infection Control Officer, Manager of Nutritional Services, Supervisor of Resident Services, Supervisor of Support Services, Director of Care and the Administrator.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dining Observation

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Skin and Wound Care

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

12 WN(s)
3 VPC(s)
2 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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s.9(1)(iii) in that the licensee did not ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to, are equipped with an audible door alarm that allows calls to be cancelled only at the point of activation.

This is related to all resident accessible stairway doors within the second, third and fourth floor resident care areas.

The home is equipped with a Tunstal Haven Model No. P019/01 resident-staff communication and response system (the system) that is connected to all resident accessible doors leading to stairways. On each resident care area, this system is composed of multiple Master Units and Speech Modules. Master Units have a display panel and are plugged into the Speech Modules which, in turn, are wall-mounted in the center core of each resident care area, common areas specifically rooms #334, #434 as well as outside the tub rooms in the resident corridors.

Each door leading to a stairway is locked and is equipped with a coded keypad to allow access to the stairways. When a door fails to close, or is held open, for a certain

amount of time, the system is activated, and staff are alerted to the open door by a long, loud tone emitted from the connected Master Unit/Speech Modules. According to the user manual provided to Inspector #161 by the Supervisor of Support Services, the door number is displayed on the Master Unit and remains visible until cancelled by staff. The point of cancellation of the system's door alert tone is at a Master Unit/Speech Module, not at the door, which is the point of activation.

On March 22, 2015 the Supervisor of Support Services indicated to Inspector #161 that when a door alert is activated on the third or fourth floors, the alert can be cancelled from any Master Unit/Speech Module located on either floor. Similarly, when a door alert is activated on the second floor, the door alert can be cancelled from any Master Unit/Speech Module located on the second or first floor. A similar discussion was held on March 25, 2015 between the Supervisor of Support Services and Inspector #161 and Inspector #556 in which the identical information was provided related to the point of cancellation of door alerts on all resident accessible doors leading to stairways.

On March 22, 2015, Inspector #161 toured the home with the Supervisor of Support Services in order to assess and discuss the home's resident-staff communication and response system including the resident accessible doors leading to stairways, located on each of the 6 resident care areas. It was determined that none of the home's resident accessible doors located on each resident care area that lead to stairways were equipped with an audible door alarm that allows calls to be cancelled only at the point of activation. The resident accessible doors tested were located in the following resident care areas: Second floor Dundas resident care area door #200; Second floor Cornwall resident care area door #250; Third floor Stormont resident care area door #300; Third floor Glengarry resident care area door #350; Fourth floor Seaway resident care area door #400; Fourth floor St Lawrence resident care area door #450.

The Supervisor of Support Services indicated to Inspector #161 that doors #200, #300 and #400 lead to one stairway and doors #250, #350 and #450 lead to another stairway. On the fourth floor, in the presence of the Supervisor of Support Services, Inspector #161 used the keypad to access resident accessible door #450 which leads to a stairway. The Inspector held the door open which in turn, activated the system's door alert tone. The door alert was audible and was immediately cancelled remotely by an unknown staff member at an unknown Master Unit location. This occurred once more when inspector #161 activated the audio alarm of resident accessible doors #400 and #300 which also lead to stairways. Once again, the audible door alert was cancelled remotely by an unknown staff member at an unknown Master Unit location.

During discussion on March 25, 2015, the Supervisor of Support Services verified with Inspector #161 and to Inspector #556, that if the resident-staff communication and response system (the system) was inoperable, there would NOT be a functional audible alarm on the resident accessible doors leading to stairways located on each of the 6 resident care areas because the door alerts are solely dependent upon the system. Thus, in this situation, there would be no way for staff to be alerted if a resident accessible door leading to a stairway was not closed.

On March 25, 2015 at 10:28 Inspector #161 held resident accessible door #200 open which in turn, activated the door alert. Staff member #S116 came immediately to the door and when questioned by Inspector #161, she indicated that the door alert could not be cancelled at the door, but rather, would have to be cancelled at a Master Unit/Speech Module, the closest one being in the resident corridor outside the tub room. Similarily, when Inspector #161 activated resident accessible door #250 alert and staff member #S117 responded to the door alert, the staff member reiterated the information provided to the Inspector previously by staff member #S116. When Inspector #161 and staff member #S117 were having a discussion at door #250, an unidentified staff member approached and validated that it was ok to turn off the audible door alert and then proceeded to reset the audible door alert using the Master Unit/Speech Module located in the resident corridor outside the tub room. Further exacerbating the risk of the non-compliance described above, is that at the base of these two stairways, there is an unlocked and unalarmed door that leads directly to the outside of the home as observed by Inspector #161 on March 25, 2015.

On March 20, 2015 discussions held with the home's Administrator and the Supervisor of Support Services, who indicated to Inspector #161 that there were issues with the resident-staff communication and response system. To this end, the home has submitted a capital replacement plan to the City of Cornwall Council for approval for the necessary funding required to replace the home's resident-staff communication and response system.

It has been established that the home's doors are not equipped with audible door alarms. They are only connected to the Tunstal Haven Model No. P019/01 resident-staff communication and response system. Over the course of the inspection, it has also been established that the home's Tunstal Haven Model No. P019/01 resident-staff communication and response system is not compliant with O.Reg. 79/10, s. 17, (1) (c), as it does not allow calls to be cancelled only at the point of activation. This has been addressed as an area of non-compliance within this inspection report under

Compliance Order #002. [s. 9. (1) 1. iii.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A3)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 17,(1) (c) in that the licensee did not ensure that the home is equipped with a resident-staff communication and response system that allows calls to be cancelled only at the point of activation.

The home is equipped with a Tunstal Haven Model No. P019/01 resident-staff communication and response system (the system) that is available at each bed, toilet, bath and shower location used by residents; as well resident common areas including dining rooms and lounges. This system is composed of multiple call bell alarm cords, Speech Modules, and Master Units. The call bell alarm cords are located in each bed, toilet, bath and shower location used by residents. A Speech Module is wall-mounted inside the entrance way to each resident's room. Each Speech Module has a large red button that can be pressed by the resident to activate the call bell system and is equipped with a built in loudspeaker. Lastly, there are Master Units which have a display panel and key pad; these units are plugged into select Speech Modules which, in turn, are wall-mounted in the center core of each resident care area, common areas specifically rooms #334, #434 as well as outside the tub rooms in the resident corridors.

When a resident activates the call bell system using either the call bell alarm cord or the red button located on the Speech Module, the module emits a long loud tone which alerts staff to the need for assistance; the display panel on the Master Unit/Speech Modules shows the door number where the call bell signal is coming from; and a white dome light above the resident bedroom door illuminates. It is of note, that when a call bell is activated on the third or fourth floors, the audible alert can be cancelled from any Master Unit/Speech Module located on either the third or fourth floor. Similarly, when a call bell is activated on the second floor, the audible alert can be cancelled from any Master Unit/Speech Module located on the second or first floor. When the audible call bell alert is cancelled at any of the Master Unit/Speech Modules, the call bell room number is no longer displayed. This action does not turn off the white dome light that has been illuminated above the resident's bedroom door. This information was verified by the Supervisor of Support Services on March 22, 2015 and again on March 25, 2015.

On March 20, 2015 Inspector #161 toured the home with the Supervisor of Support Services in order to assess and discuss the home's resident-staff communication and response system including the resident call-bell system. Using Resident room #4024 call bell system, as per Inspector #161's request, the Supervisor of Support Services activated the call bell system in the Resident's room by pushing the red button located on the Speech Module. A loud tone was emitted from the Speech Module located in the Resident's room as well as at all Master Unit/Speech Modules in the Inspector's general vicinity. Using the Master Unit/Speech Module located at the sitting area in the central corridor adjacent to the nursing station; Inspector #161 pressed a sequence of

keys on the keypad and thus silenced the audible call bell alert, noting that the call bell room number was no longer displayed on the Master Unit/Speech Module. This action did not turn off the white dome light which was illuminated above the Resident's bedroom door. The call bell system was subsequently reset in the Resident's room by the Supervisor of Support Services.

On March 27, 2015 at 09:00, Inspector #161 activated the call bell system in Resident room #2016 by pushing the red button located on the Speech Module. PSW #S125 turned off the audible alarm at the Master Unit/Speech Module located at the sitting area in the central corridor adjacent to the nursing station, not at the point of activation in the Resident's room. This also occurred when Inspector #161 activated the call bell alert system in rooms #4024, #3023 and #3040.

In summary, while verifying the operation of the home's call-bell system Inspector #161 noted over the course of the inspection, that the home's "call bell system" is not compliant with O. Reg. 79/10, s.17,(1) (c) as it allows the audible call bell alarm to be cancelled at points other than where activated. [s. 17. (1) (c)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A3)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

During this inspection, the resident common areas and the dining room on the 2nd floor Cornwall unit and the 3rd floor Glengarry unit, it was observed that the finishing on the wood panelling of the lower walls was found to be in disrepair and the walls had extensive horizontal scuff marks and scratches . It was also observed on the 2nd and 3rd floor units, that the varnish on the wooden hand rails and the wood shelving found in the hallways near the entrance of resident rooms is worn off, exposing the grain of wood and that some parts of the wooden hand rails is chipped along the edges of the rail.

In the Tub and shower room on the 2nd floor Cornwall unit, Inspector #550 observed that the varnish is completely worn off on the shower seat made of wood. The varnish on the wooden bench on both the tub and shower area was well-worn off. On the 3rd floor Stormont unit, in the shower room the linoleum baseboard is broken exposing the gyprock underneath and the wooden bench in shower and tub area the varnish is well worn off.

An interview with the home's Supervisor of Support Services indicated that he is aware of some of the issues identified by Inspectors. Further he stated that they have done painting and repair work for the wood panelling of the lower walls in the past but nothing done regarding worn off varnish for the hand rails and furniture. The Supervisor of Support Services mentioned that it is an ongoing challenge for the home regarding maintaining the lower wall wood panelling from scratches and the home will continue to look various options to maintain the home furnishings in a good state of repair. [s. 15. (2) (c)]

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 wood panelling throughout the home and the finish on furniture and handrails are kept in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

The licensee has failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Complaint Log #O-001826-15:

A review of resident #025's care plan indicated the resident is to be assisted with bath/shower two times weekly.

A review of the progress notes for March 2015 on the Resident's health care record indicated:

On a date in March 2015 Resident #025's Power of Attorney (POA) stated to the

nurse that she had spoken to the DOC and that Resident #025 was to get his/her bath this evening since the resident was not bathed on their scheduled day. Writer informed the POA that Resident #025 was not the only one that missed a bath. Advised Resident #025's POA that there was a set schedule and it is difficult to put extra baths into the schedule as the bath person is only on the floor for a certain time and is responsible for baths on both second floor units.

Twelve days later in March 2015 Resident #025's POA approached writer asking me to call someone in to give Resident #025 a bath, attempted to explain that there was no one to come in.

The following day in March 2015 Resident #025's POA expressed concerns regarding the resident's care stating that the resident "did not receive his/her bath yesterday and I want him to have one today but they won't do it"

A total of 5 PSW's were interviewed from 2 separate units, some of whom work days and some who work evenings, and they all indicated that on evening shift there is a staff member scheduled to do baths on both of the units on a specified floor. Normally the bath person is assigned 4-6 baths during a shift and when they don't come to work the residents scheduled to receive a bath are not bathed. If a staff member scheduled to work day shift does not come to work and cannot be replaced then the residents scheduled to receive baths on that shift are not bathed. The PSW's further indicated that baths are not rescheduled, if a bath is missed the resident has to wait until their next scheduled bath day to receive a bath. They also indicated that when baths are not completed it is either marked on a calendar or recorded in the communication book.

A review of the communication book on both of these units located on a specified floor indicated that on 5 dates from January 1 – March 23, 2015, that no baths were given due to shortage of staff. Furthermore, a review of the March 2015 calendar posted on the bulletin board on one of the units, indicated that for 3 dates in March 2015, the baths were not given. [Log #O-001826-15] [s. 33. (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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Resident #019 was assessed to have a wound on a specified date in November 2014. The treatment plan on the Wound Assessment / Progress Tool indicated: cleanse with normal saline, apply 4 x 4, Actisorb silver, abdominal pad and Hypafix, prep surrounding area with Cavillon and change on bath days. The treatment plan on the Wound Assessment / Progress Tool that covers from a specified date in January 2015 to a specified date in February 2015, indicated: cleanse with normal saline, prep surrounding skin with Cavillon, apply Mesalt, Actisorb Silver, 4 x 4 gauze and Hypafix.

Inspector reviewed Resident #019's physician orders with RPN staff #S105 and observed there was no physician order for the treatment plans for this resident's wound.

During an interview, the Director of Care indicated to Inspector #550 the treatment for Resident #019's wound should have been ordered by either the physician or the nurse practitioner. [s. 131. (1)]

2. The licensee has failed to ensure that a member of the registered nursing staff permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical only if:
(a) The staff member has been trained by a member of the registered nursing staff in the administration of topicals
(b) The member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and
(c) The staff member who administers the topical does so under the supervision of the member of the registered nursing staff.

During an interview PSW staff #108 indicated to Inspector #550 she applies prescribed topical creams to several residents on a daily basis and gave examples of Residents whom the PSW's apply topical creams to such including:
Resident #021 cream for his/her buttocks,
Resident #022 cream for blisters on his/her hands and topical scalp lotion,
Resident #003 cream for under her/his breast and,
Resident #024 cream for hemorrhoids, cream for his/her buttocks and scalp lotion.
PSW staff #S108 indicated to Inspector #550 she has been working at the home for 5 years and has never received training on how to apply topical creams to residents; she indicated she received some training during her PSW course but never received any training here at the home.

PSW staff #S109 indicated to Inspector #550 she was recently hired at the home and

that she received training by another PSW during her orientation on how to apply topical creams to residents but she did not receive any training by Registered Staff.

PSW staff #S110 indicated to Inspector #550 PSW's apply prescribed cream to residents on a daily basis. She indicated to Inspector she has been working at the home for 13 years and she never received any training on the application of topical creams from the registered staff at the home.

The Director of Care indicated to Inspector #550 during an interview she was not aware that when a member of the registered nursing staff permitted a PSW to administer a topical to a resident that the PSW had to be trained by a member of the registered nursing staff. She indicated she did not interpret the Regulation this way. [s. 131. (4)]

3. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

During an interview, RPN staff #S107 indicated to Inspector #550 Resident #020 self-administers an inhaler and a nebulizer. She indicated registered staff will document in the MAR sheets even though the resident self-administers the medications and keeps them in their room.

During an interviewed Resident #020 indicated to Inspector #550 that she/he self-administers her/his Ventolin puffer and Ventolin nebulizer. The resident showed inspector one Ventolin inhaler and nebules that the resident keeps in their dresser.

Inspector #550 reviewed Resident #020's health records. The Physician's Medication Review form for the period of February 1, 2015 to April 30, 2015 indicated Resident #020 has a physician's order for an inhaler - 2 puffs every 2 to 3 hours as needed (May keep at bedside), as well as inhale contents of 1 specified nebule via nebulizer every 4 hours while awake instead of inhaler if resident wishes; and use the inhaler 2 puffs by mouth every 4 hours while awake. There was no physician order indicating Resident #020 can self- administer any medication.

RPN staff #S105 reviewed Resident #020's health records with Inspector #550. There was no documentation indicating Resident #020 is permitted to self- administer any medication.

The Director of Care indicated to Inspector #550 during an interview that the home's policy titled "Self Administrating Residents", dated July 2014 is in evolution. She indicated it was discussed at the home's PAC meeting on March 9th, 2015 and at the Registered Staff meeting on March 18, 2015. She further indicated Residents who self-medicates should have a physician's order permitting them to do so. [s. 131. (5)]

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 only drugs that have been prescribed for a resident are used by or administered to a resident; that a staff member who is not otherwise permitted to administer a topical has been trained by a member of the registered nursing staff to administer topicals and; that all Resident who administer drugs to him or her self, must have the administration approved by the prescriber., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Inspector #550 reviewed Resident #019's health record and observed it was documented the resident's most recent care plan on a specified date in March 2015 that the resident has a specified stage-sized wound and requires dressing changes to the wound as per wound care book. Inspector then observed the Wound Assessment / Progress Tool form in the wound care book for Resident #019 that covers from a specified date in January 2015 to a specified date in February 2015 and observed the type of wound to be documented as a different stage-size. The treatment plan was documented as follows: Cleanse with N/S, prep surrounding skin with Cavillon, apply Mesalt, Actisorb Silver, 4 x4 gauze and hypafix. The last assessment date on this form for this wound was a specified date in February 2015 and indicated the stage of the wound. No further documentation was observed after this date.

During an interview, Resident #019 indicated to Inspector #550 that the wound was healed and that staff no longer needed to do any dressings.

During an interview, RPN staff #S105 who is the regular RPN on this unit indicated to Inspector #550, that Resident #019 had a wound and that it had decreased in size.

Inspector observed Resident #019's skin with RPN staff #S123 and observed the resident's skin to be intact.

Inspector reviewed the progress notes from a specified date in February 2015 to a specified date in March 2015 and observed there was no documentation that the wound had healed. [s. 6. (1) (c)]

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

The licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s.29 (1)(b), whereby the licensee did not ensure that their written policy to minimize the restraining of residents and that any restraining that is necessary is done in accordance with this Act and the regulations, is complied with.

The home's policy DM3 -0501-80 dated February 2010 titled "Least Restraint" under bullet point #1(1.2)(1) that "The Multidisciplinary Team must investigate cause, alternate solutions and evaluate effectiveness using the Restraint Alternatives Form (N-77) and under#1.5 request family/substitute decision-maker to sign form (N-79) for consent to apply restraint after the team has educated the family of the home's least restraint philosophy and its benefits.

A review of Resident #005's and Resident #017's health care record indicates a physician's order for the use of seat belt restraint in the wheelchair. The use of the seat belt restraint is also included in the Resident #005's and #017's care plan but there was no documentation found in the Residents health care records regarding any alternatives to restraining the residents considered (Form N-77) nor a signed consent for the use of a seat belt restraint (Form N-79) as per the home's policy.

On March 23, 2015 the home's Kinesiologist #S 111 who is the primary lead for the Restraint multidisciplinary team indicated to Inspector #573 that before any type of restraint is used, she and the team would consider restraint alternatives by initiating or using Form (N-77). She further stated that if the resident is on any type of Restraint, she or Registered Nursing staff would obtain written consent for Restraints by using Form (N-79) from Resident or the Substitute Decision-Maker.

Registered staff member #S 112 and Kinesiologist #S 111 reviewed the Resident's #005 and #017 health care records with Inspector #573 and could not locate or find the Restraint Alternatives Form (N-77) nor a signed Consent Form (N-79) for both the Residents.

On March 24, 2015 the Director of Care stated to Inspector #573 that the expectation of the Kinesiologist S# 111 who is the primary lead for Restraints is to initiate and complete Restraint Alternatives Form (N-77) and further stated that the Registered Nursing Staff or Kinesiologist #S 111 is to obtain the Resident or Substitute decision maker's written consent for the use of Restraints by using Form (N-79) as per the home's policy. [s. 29. (1) (b)]

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the restraining of Resident #003 by a physical device was ordered or approved by a physician, or registered nurse in the extended class.

On a specified date in March 2015 Inspector #573 observed Resident #003 to have a wheelchair seatbelt in place.

The monthly flow sheets for Resident #003 were reviewed and under the section entitle "Safety Devices and Restraints that Restrict Movement" the documentation completed by the PSW staff indicated that a seatbelt or lap restraint had been applied 52 times in January 2015, and 49 times in February 2015.

On a specified date in March 20 2015 Inspector #161 interviewed RPN #S104, and RPN #S105 both of whom indicated that the seatbelt worn by Resident #003 was a restraint, and that the resident doesn't have the cognitive or physical ability to remove the seatbelt.

In an interview PSW #S124 stated that Resident #003 has been wearing a seatbelt restraint for the past 4 years.

The physician's orders in Resident #003's health care record were reviewed with the assistance of RN S#123 and no order for a seatbelt restraint could be located. [s. 31. (2) 4.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital.

Resident #19 was admitted to the hospital on a specified date in July 2014, returned two days later, and was readmitted again that same day and returned back to the home a few days later. The Inspector reviewed the resident's health records and progress notes from July 2014 and observed that no skin assessment was done upon the resident's return to the home.

During an interview, RPN staff #S105 indicated to Inspector #550 staff will do not do any skin assessments on residents upon a return from a leave of absence for more than 24 hours or upon a return from a hospital unless the staff observe an issue with the resident's skin integrity.

During an interview, the Director of Care indicated to Inspector #550 that she was unaware the Regulations required residents who were exhibiting altered skin integrity receive a skin assessment upon a return from hospital or a leave of absence of more than 24 hours and she will have to amend the home's policy. She indicated the registered nursing staff are currently not performing skin assessments on residents who exhibit altered skin integrity upon return from hospital. She indicated Resident #19 does have altered skin integrity. [s. 50. (2) (a) (ii)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Inspector #550 reviewed the documentation for Resident #19's pressure ulcer from a specified date in October 2014 to a specified date in March 2015 on the Wound Assessment /Progress Tool and observed that there was no documentation for a week in December, 2014; 2 weeks in January 2015 and nothing beyond a specified date in February 2015 to the end of March 2015.
During an interview, the Director of Care indicated to Inspector #550 wounds are to be assessed and documented on a weekly basis assessments at a minimum and whenever the dressing is changed. Resident #19's dressing plan indicated the dressing had be changed on bath day. Since Resident #19 had their baths on two different days of the week, the dressing should have been changed and documented upon two times per week. She indicated the dressing changes and wound assessments are documented on the Wound Assessment /Progress Tool. [s. 50. (2) (b) (iv)]

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee did not respond in writing within 10 days of receiving a concern or recommendation to the Residents' Council.

The Vice President of Residents Council indicated during an interview with Inspector #573 that she was not sure that the Licensee responds in writing within 10 days of receiving a concern or recommendation from the Residents' Council. The Vice President further indicated that the concerns were addressed in writing in the next or subsequent Council meeting.

Inspector #573 reviewed the Residents Council meeting minutes for the month of January 2015. The Residents' Council meeting minutes of January 27, 2015 identified concerns from the 3rd and 4th floor residents regarding food temperature and plate warming concerns. The Administrator's written response to the Resident Council concerns was done on February 13, 2015.

On March 24, 2015 The Resident Service Supervisor who does the assistant Duties for the Resident's Council reported to Inspector #573 that the response to any concerns and recommendations from the Resident Council is documented and usually presented to the Resident Council in the next subsequent council meeting. She further stated that for the concerns on January 27, 2015 Residents' Council meeting the written response was not provided within 10 days to the Residents Council. [s. 57. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the daily and weekly menus communicated to residents.

On March 16, 2015 Inspector #550 observed at lunchtime that the weekly menu was not posted in the Dundas dining room on the second floor.

On March 18, 2015 Inspector #550 observed at lunchtime that the weekly and the daily menu were not posted in the Stormont and the Glengarry dining rooms on the third floor.

On March 19, 2015 Inspector # 550 observed at lunchtime the weekly menu was not posted in the Stormont and the Glengarry dining rooms on the third floor.

During an interview, PSW staff #S110 indicated to Inspector #550 that the daily menu is usually posted on the television at the entrance of the Glengarry dining room but that the television is not working at this time. She also indicated the daily menu is usually posted on the white board on the Stormont dining room.

During an interview, the Manager of Nutritional Services indicated to Inspector #550 it is her expectation that the weekly menu and the daily menu are posted in the dining room on each unit and that it is the responsibility of the Dietary Aids to do so. She further indicated the daily menus used to be posted on the televisions at the entrance of the dining rooms but the person who used to do the data entry on the television is no longer working at the home and was not replaced. [s. 73. (1) 1.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

The licensee has failed to ensure that all assessment, reassessment and monitoring, including the resident's response to the use of a physical device to restrain Resident #003 was documented.

On a specified date in March 2015 Inspector #573 observed Resident #003 to have a wheelchair seatbelt in place.

On March 20, 2015 Inspector #161 interviewed RPN #S104, and RPN #S105 both of whom indicated that the seatbelt worn by Resident #003 was a restraint, and that the resident doesn't have the cognitive or physical ability to remove the seatbelt.

In an interview PSW #S124 stated that Resident #003 has been wearing a seatbelt restraint for the past 4 years and that the resident is not able to remove the wheelchair seatbelt on their own.

A review of the Restraint Binder where the Restraint Observation Records are kept, and where staff document the hourly observation of residents with restraints, indicated that on a specified date in March 2015 documentation of hourly observations of Resident #003 was initiated due to the use of a seat belt restraint.

Towards the end of March 2015 at the request of Inspector #556, RPN #S107 reviewed the Restraint Observation Record for Resident #003 which had a notation stating "initiated on a specified date in March 2015" and stated that there is no other place that hourly observations of residents who are restrained are documented. RPN #107 looked through the archived file for Resident #003 and did not find any completed Restraint Observation Records and stated that there is a very clear process in the home regarding restraints and since there are no Restraint Observation Records on her file, and the notation indicates that a Restraint Observation Record was initiated on that specified date in March 2015, then prior to that, hourly documentation of Resident #003 while wearing a seatbelt was not being completed. [s. 110. (7) 6.]

Issued on this 22 day of October 2015 (A3)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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, Suite 420
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston, bureau 420
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : KATHLEEN SMID (161) - (A3)

Inspection No. / No de l'inspection : 2015_384161_0006 (A3)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : O-001745-15 (A3)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Oct 22, 2015;(A3)

Licensee / Titulaire de permis : THE CORPORATION OF THE CITY OF CORNWALL
1900 Montreal Rd., CORNWALL, ON, K6H-7L1

LTC Home / Foyer de SLD : GLEN-STOR-DUN LODGE
1900 MONTREAL ROAD, CORNWALL, ON, K6H-7L1

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Norm Quenneville

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To THE CORPORATION OF THE CITY OF CORNWALL, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

(A3)
In order to achieve compliance with O. Reg. 79 10, s. 9 (1) 1. iii, the licensee shall ensure that all resident accessible doors leading to stairways, and all resident accessible doors leading to the outside of the home, other than doors leading to secure outside areas that preclude exit by a resident, are equipped with an audible door alarm that allows calls to be cancelled only at the point of activation AND, is connected to the resident-staff communication and response system, or, be connected to an audio visual enunciator that is connected to the nurses station nearest to the door and has a manual reset switch at each door.

The licensee will implement measures to ensure resident safety until such time as compliance is achieved with O. Reg. 79 10, s. 9 (1) 1. iii.

The licensee has requested an extension to the compliance date for this Compliance Order #001 issued as a result of the Resident Quality Inspection conducted in April 2015. The compliance date for the order was originally September 30, 2015 and was amended as per licensee request to November 30, 2015.

The licensee has provided a letter dated October 16, 2015 with an explanation of the factors that are delaying their ability to achieve full compliance by the compliance date of November 15, 2015. The compliance date is amended to reflect a new date of August 30, 2016. The licensee will implement measures to ensure resident safety until such time as compliance is achieved with O. Reg. 79 10, s. 9 (1) 1. iii.

Grounds / Motifs :

1. The licensee failed to comply with O.Reg 79/10, s.9(1)(iii) in that the licensee did not ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to, are equipped with an audible door alarm that allows calls to be cancelled only at the point of activation.

This is related to all resident accessible stairway doors within the second, third and fourth floor resident care areas.

The home is equipped with a Tunstal Haven Model No. P019/01 resident-staff communication and response system (the system) that is connected to all resident accessible doors leading to stairways. On each resident care area, this system is composed of multiple Master Units and Speech Modules. Master Units have a display panel and are plugged into the Speech Modules which, in turn, are wall-mounted in the center core of each resident care area, common areas specifically rooms #334, #434 as well as outside the tub rooms in the resident corridors.

Each door leading to a stairway is locked and is equipped with a coded keypad to allow access to the stairways. When a door fails to close, or is held open, for a certain amount of time, the system is activated, and staff are alerted to the open door by a long, loud tone emitted from the connected Master Unit/Speech Modules. According to the user manual provided to Inspector #161 by the Supervisor of Support Services, the door number is displayed on the Master Unit and remains visible until cancelled by staff. The point of cancellation of the system's door alert tone is at a Master Unit/Speech Module, not at the door, which is the point of activation.

On March 22, 2015 the Supervisor of Support Services indicated to Inspector #161 that when a door alert is activated on the third or fourth floors, the alert can be cancelled from any Master Unit/Speech Module located on either floor. Similarly, when a door alert is activated on the second floor, the door alert can be cancelled from any Master Unit/Speech Module located on the second or first floor. A similar discussion was held on March 25, 2015 between the Supervisor of Support Services and Inspector #161 and Inspector #556 in which the identical information was provided related to the point of cancellation of door alerts on all resident accessible doors leading to stairways.

On March 22, 2015, Inspector #161 toured the home with the Supervisor of Support Services in order to assess and discuss the home's resident-staff communication and response system including the resident accessible doors leading to stairways, located on each of the 6 resident care areas. It was determined that none of the home's resident accessible doors located on each resident care area that lead to stairways were equipped with an audible door alarm that allows calls to be cancelled only at the point of activation. The resident accessible doors tested were located in the following resident care areas: Second floor Dundas resident care area door #200; Second floor Cornwall resident care area door #250; Third floor Stormont

resident care area door #300; Third floor Glengarry resident care area door #350; Fourth floor Seaway resident care area door #400; Fourth floor St Lawrence resident care area door #450.

The Supervisor of Support Services indicated to Inspector #161 that doors #200, #300 and #400 lead to one stairway and doors #250, #350 and #450 lead to another stairway. On the fourth floor, in the presence of the Supervisor of Support Services, Inspector #161 used the keypad to access resident accessible door #450 which leads to a stairway. The Inspector held the door open which in turn, activated the system's door alert tone. The door alert was audible and was immediately cancelled remotely by an unknown staff member at an unknown Master Unit location. This occurred once more when inspector #161 activated the audio alarm of resident accessible doors #400 and #300 which also lead to stairways. Once again, the audible door alert was cancelled remotely by an unknown staff member at an unknown Master Unit location.

During discussion on March 25, 2015, the Supervisor of Support Services verified with Inspector #161 and to Inspector #556, that if the resident-staff communication and response system (the system) was inoperable, there would NOT be a functional audible alarm on the resident accessible doors leading to stairways located on each of the 6 resident care areas because the door alerts are solely dependent upon the system. Thus, in this situation, there would be no way for staff to be alerted if a resident accessible door leading to a stairway was not closed.

On March 25, 2015 at 10:28 Inspector #161 held resident accessible door #200 open which in turn, activated the door alert. Staff member #S116 came immediately to the door and when questioned by Inspector #161, she indicated that the door alert could not be cancelled at the door, but rather, would have to be cancelled at a Master Unit/Speech Module, the closest one being in the resident corridor outside the tub room. Similarily, when Inspector #161 activated resident accessible door #250 alert and staff member #S117 responded to the door alert, the staff member reiterated the information provided to the Inspector previously by staff member #S116. When Inspector #161 and staff member #S117 were having a discussion at door #250, an unidentified staff member approached and validated that it was ok to turn off the audible door alert and then proceeded to reset the audible door alert using the Master Unit/Speech Module located in the resident corridor outside the tub room. Further exacerbating the risk of the non-compliance described above, is that at the base of these two stairways, there is an unlocked and unalarmed door that leads

directly to the outside of the home as observed by Inspector #161 on March 25, 2015.

On March 20, 2015 discussions held with the home's Administrator and the Supervisor of Support Services, who indicated to Inspector #161 that there were issues with the resident-staff communication and response system. To this end, the home has submitted a capital replacement plan to the City of Cornwall Council for approval for the necessary funding required to replace the home's resident-staff communication and response system.

It has been established that the home's doors are not equipped with audible door alarms. They are only connected to the Tunstal Haven Model No. P019/01 resident-staff communication and response system. Over the course of the inspection, it has also been established that the home's Tunstal Haven Model No. P019/01 resident-staff communication and response system is not compliant with O.Reg. 79/10, s. 17, (1) (c), as it does not allow calls to be cancelled only at the point of activation. This has been addressed as an area of non-compliance within this inspection report under Compliance Order #002. (161)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Aug 30, 2016(A3)

Order # /
Ordre no : 002

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,

(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

(b) is on at all times;

(c) allows calls to be cancelled only at the point of activation;

(d) is available at each bed, toilet, bath and shower location used by residents;

(e) is available in every area accessible by residents;

(f) clearly indicates when activated where the signal is coming from; and

(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Order / Ordre :

(A3)
In order to achieve compliance with O. Reg. 79 10, s.17,(1) (c), the licensee shall ensure that the home is equipped with a resident-staff communication and response system that allows calls to be cancelled only at the point of activation.

The licensee will implement measures to ensure resident safety until such time as compliance is achieved with O. Reg. 79 10, s. 17, (1) (c).

The licensee has requested an extension to the compliance date for this Compliance Order #002 issued as a result of the Resident Quality Inspection conducted in April 2015. The compliance date for the order was originally September 30, 2015 and was amended as per licensee request to November 30, 2015.

The licensee has provided a letter dated October 16, 2015 with an explanation of the factors that are delaying their ability to achieve full compliance by the compliance date of November 15, 2015. The compliance date is amended to reflect a new date of August 30, 2016. The licensee will implement measures to ensure resident safety until such time as compliance is achieved with O. Reg. 79 10, s. 17, (1) (c).

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg. 79/10, s. 17,(1) (c) in that the licensee did not ensure that the home is equipped with a resident-staff communication and response system that allows calls to be cancelled only at the point of activation.

The home is equipped with a Tunstal Haven Model No. P019/01 resident-staff communication and response system (the system) that is available at each bed, toilet, bath and shower location used by residents; as well resident common areas including dining rooms and lounges. This system is composed of multiple call bell alarm cords, Speech Modules, and Master Units. The call bell alarm cords are located in each bed, toilet, bath and shower location used by residents. A Speech Module is wall-mounted inside the entrance way to each resident's room. Each Speech Module has a large red button that can be pressed by the resident to activate the call bell system and is equipped with a built in loudspeaker. Lastly, there are Master Units which have a display panel and key pad; these units are plugged into select Speech Modules which, in turn, are wall-mounted in the center core of each resident care area, common areas specifically rooms #334, #434 as well as outside the tub rooms in the resident corridors.

When a resident activates the call bell system using either the call bell alarm cord or the red button located on the Speech Module, the module emits a long loud tone which alerts staff to the need for assistance; the display panel on the Master Unit/Speech Modules shows the door number where the call bell signal is coming from; and a white dome light above the resident bedroom door illuminates. It is of note, that when a call bell is activated on the third or fourth floors, the audible alert can be cancelled from any Master Unit/Speech Module located on either the third or fourth floor. Similarly, when a call bell is activated on the second floor, the audible alert can be cancelled from any Master Unit/Speech Module located on the second or first floor. When the audible call bell alert is cancelled at any of the Master Unit/Speech Modules, the call bell room number is no longer displayed. This action does not turn off the white dome light that has been illuminated above the resident's bedroom door. This information was verified by the Supervisor of Support Services on March 22, 2015 and again on March 25, 2015.

On March 20, 2015 Inspector #161 toured the home with the Supervisor of Support Services in order to assess and discuss the home's resident-staff communication and response system including the resident call-bell system. Using Resident room

#4024 call bell system, as per Inspector #161's request, the Supervisor of Support Services activated the call bell system in the Resident's room by pushing the red button located on the Speech Module. A loud tone was emitted from the Speech Module located in the Resident's room as well as at all Master Unit/Speech Modules in the Inspector's general vicinity. Using the Master Unit/Speech Module located at the sitting area in the central corridor adjacent to the nursing station; Inspector #161 pressed a sequence of keys on the keypad and thus silenced the audible call bell alert, noting that the call bell room number was no longer displayed on the Master Unit/Speech Module. This action did not turn off the white dome light which was illuminated above the Resident's bedroom door. The call bell system was subsequently reset in the Resident's room by the Supervisor of Support Services.

On March 27, 2015 at 09:00, Inspector #161 activated the call bell system in Resident room #2016 by pushing the red button located on the Speech Module. PSW #S125 turned off the audible alarm at the Master Unit/Speech Module located at the sitting area in the central corridor adjacent to the nursing station, not at the point of activation in the Resident's room. This also occurred when Inspector #161 activated the call bell alert system in rooms #4024, #3023 and #3040.

In summary, while verifying the operation of the home's call-bell system Inspector #161 noted over the course of the inspection, that the home's "call bell system" is not compliant with O. Reg. 79/10, s.17,(1) (c) as it allows the audible call bell alarm to be cancelled at points other than where activated. (161)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Aug 30, 2016(A3)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 22 day of October 2015 (A3)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : KATHLEEN SMID - (A3)

Service Area Office /
Bureau régional de services : Ottawa