Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 5, 2017	2017_682549_0014	019236-17	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

RENA BOWEN (549), KATHLEEN SMID (161)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 27, 28, 29, 30 and December 1, 2017

The following Logs where inspected concurrently: Log # 006503-17 and 007601-17 related to fall prevention.
Log # 009151-17 related to suspected physical abuse
Log # 012827-17 related to suspected resident to resident abuse
Log # 018098-17 related to suspected resident to resident sexual abuse
Log # 025862-17 related to provision of care being provided

During the course of the inspection, the inspector(s) spoke with residents, family members, the Family Council President, the Resident Council President, the Resident Council Assistant, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), a Housekeeping Aide, the Staff Development/Infection Control Practitioner, the Director of Care (DOC) and the Administrator.

The inspectors reviewed resident health care files, restraint documentation binder, the licensee's policy titled Resident non Abuse, #MM-0704-08 revised March 2017, observed a medication administration pass, resident to resident and staff to resident interactions, drug storage areas, infection control practices and toured resident areas.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

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

- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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 :

1. 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.

Resident #006 was admitted to the home on a specific date in 2017.

The resident was observed by Inspector #161 and Inspector #549 on specific dates in November 2017 seated in a wheelchair with a restraint device applied. The resident was unable to undo the restraint device when requested by Inspector #549.

During an interview on November 29, 2017, Personal Support Worker (PSW) #105 indicated to the inspector that resident #006 is not able to undo the restraint device. PSW #105 indicated that the restraint device is considered a restraint.

PSW #105 indicated to the inspector that direct care staff have a binder at the documentation station that has the written plan of care for each resident. The direct care staff are to refer to the binder for directions when providing care to the residents.

Inspector #549 reviewed the written plan of care for resident #006 last updated on a specific date in November 2017 with PSW #105 and Charge Registered Nurse (RN) #106. Charge RN #106 was unable to locate any documentation in the written plan of care that include any directions to the direct care staff related to resident #006's restraint.

On November 30, 2017, the Director of Care (DOC) and Administrator indicated to Inspector #549 that the home's expectation is that resident #006's restraint be documented in the residents written plan of care to provide clear direction to staff providing care.

As such, the licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #006 related to the restraint. [s. 6. (1) (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 plan of care sets out clear directions to staff and others who provide care to the residents who have restraints applied, to be implemented voluntarily.

WN #2: 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:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

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 :

1. The licensee has failed to 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 is documented: the person who applied the restraint and the time of application.

Resident #010 was admitted to the home on a specific date in 2010.

Resident #010 was observed by Inspector #549 on a specific date in November 2017

sitting in a wheelchair with a restraint device and cover applied. The resident was unable to undo the restraint device when requested by Inspector #549.

Inspector #549 reviewed the resident's health care record. The health care record included a physician's order for a restraint with the cover and a consent signed by the Substitute Decision Maker (SDM) for it to be applied

During an interview with PSW #108, #109 and #111 on November 29, 2017 it was indicated to the inspector that the resident no longer required the restraint with a cover applied as it was discontinued. Therefore, there was no documentation related to the restraint. The PSWs indicated that they where unsure as to when the restraint was discontinued.

On a specific date in November 2017, Inspector #549 observed a written direction that indicated the resident is to have the restraint with a cover applied when up in wheelchair at all times.

Inspector #549 reviewed the resident's physician orders for specific period in 2017 and was unable to locate an order to discontinue the resident's restraint.

Resident #010's current written plan of care last reviewed on a specific date in October 2017 indicated the following: apply a restraint device with black cover; check hourly and remove and readjust. Document on the restraint observation record. Family consent has been obtained. Physician orders obtained. Orange tag on wheelchair indicate resident is a restraint.

Inspector #549 and PSW #108 reviewed the restraint binder where the restraint documentation is kept and were unable to locate any restraint documentation for resident #010.

During an interview with the unit Registered Practical Nurse (RPN) #113 on November 29, 2017 it was indicated to the inspector that there was some discussion about the resident's restraint however, there was no order to discontinue the restraint with a cover.

As such, the licensee has failed to ensure that the person who applied the device including the time is documented. [s. 110. (7) 5.]

2. The licensee has failed to ensure all assessments, reassessments and monitoring,

including the resident’s response is documented.

Resident #010 was admitted to the home on a specific date in April 2010.

Resident #010 was observed by the Inspector #549 on a specific date in November 2017 sitting in a wheelchair with a restraint device and cover applied.

Inspector #549 reviewed the resident's health care record. The resident's health care record included a physician’s order for a restraint with a cover and a consent signed by the SDM for it to be applied

Inspector #549 and PSW #108 reviewed the unit restraint binder where the restraint documentation is kept and was unable to locate any restraint documentation for resident #010.

During an interview with RPN #113 on November 29, 2017 is was indicated to the inspector that RPNs document every assessment, reassessments, monitoring, including the resident's response to the restraint in the unit restraint binder.

During the same interview with RPN #113 it was indicated to Inspector #549 that there was no documentation for resident #010’s reassessment, monitoring, including the resident's response to the restraint.

On November 29, 2017, the DOC indicated to Inspector #549 that the home's expectation is that all assessments, reassessments and the effectiveness of the restraint be documented.

As such, the licensee has failed to ensure that the all assessments, reassessments and monitoring, including the resident’s response is documented. [s. 110. (7) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every use of a physical device to restrain a resident under section 31 of the Act has documentation indicating the person who applied the restraint, the time of the application, every assessment, reassessment and monitoring, including the resident's response to the restraint, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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).

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:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint plan of care includes an order by the physician or the registered nurse in the extended class.

Resident #021 was admitted to the home on a specific date in October 2017.

The resident was observed by Inspector #549 on a specific date in November 2017 sitting in a wheelchair with a restraint device applied.

PSW #108, #109 and #110 all indicated on November 29, 2017 to the inspector that the

resident was able to undo the restraint.

Inspector #549 asked resident #021 to undo the restraint in the presence of the PSWs. The resident was unable to undo the restraint. PSW #108 also asked the resident to undo the restraint, the resident was unable to do so.

Review of the resident's health care record and physician's order Inspector #549 was unable to locate an order for a restraint.

RPN #113 indicated to the inspector that she is aware that a physician's order or a registered nurse in the extended class and a consent for the seat belt restraint is required for all residents who have a restraint.

On November 30, 2017, the DOC indicated to the inspector that the home's expectation is to obtain a physician's or a registered nurse in the extended class order to apply resident #021's restraint.

As such, the licensee has failed to ensure that resident #021's restraint plan of care includes an order by the physician or the registered nurse in the extended class. [s. 31. (2) 4.]

2. The licensee failed to ensure that the restraint plan of care includes the consent by the resident or if the resident is incapable, by the SDM.

Resident #021 was admitted to the home on a specific date in October 2017. The Minimum Data Set (MDS) assessement dated a specific date in October 2017 indicates that the resident's cognitive skills for daily decision-making is severely impaired-never/rarely makes decisions.

The resident was observed on a specific date in November 2017 by Inspector #549 sitting in a wheelchair with a restraint device applied.

Inspector #549 asked the resident to undo the restraint. The resident was unable to undo the restraint when asked. PSW #108 also asked the resident to undo the restraint, the resident was unable to do so.

RPN #113 indicated to the inspector that the resident has a SDM who makes all the care decisions for resident #021.

Inspector #549 reviewed resident #021's health care record on November 29, 2017 and was unable to locate a consent for the restraint signed by the resident's SDM.

RPN #113 indicated during an interview on November 29, 2017 that the resident #021's health care record did not include a signed consent to apply a restraint. RPN #113 indicated that she is aware that a consent is required for all residents who have a physical restraint applied.

On November 30, 2017, the DOC indicated to the inspector that the home's expectation is to obtain a consent from resident #021's SDM to apply the restraint.

As such, the licensee has failed to ensure that the restraint plan of care includes a consent signed by resident #021's SDM. [s. 31. (2) 5.]

Issued on this 5th day of December, 2017

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

Original report signed by the inspector.