Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 31, Jun 1, 7, 2011	2011_048175_0001	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

BRENDA THOMPSON (175) and Amanda Nixon (148)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Registered Nursing staff and Personal Support Workers on 3rd Floor Nursing Unit, Laundry Manager, the Administrator, Residents 3rd Floor Nursing Unit

During the course of the inspection, the inspector(s) Reviewed resident health records including daily care flow sheets, the Glengarry and Stormont bath lists, medication administration records, medication storage areas, linen supply storage room on 3rd Floor Nursing Unit and Main Laundry Room, Supply Stock Room 3rd Floor Nursing Unit and Room "77" Basement Level, Absentee-Replacement Records, Registered Nurse Complement document, Registered Nurse Schedule.

The following Inspection Protocols were used in part or in whole during this inspection:

Accommodation Services - Laundry

Medication

Personal Support Services

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Definitions	Définitions
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.) 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. 131. Administration of drugs

Specifically failed to comply with the following subsections:

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).

Findings/Faits sayants :

1. 1. June 1, 2011 medication administration records and medication storage were reviewed. Oral Tylenol #3 for one resident as ordered to be given 4 times per day and 1 dose per day when needed. It was confirmed that the Tylenol #3 was borrowed from another resident on May 30, 31, 4 doses per day and on June 1, 2011, the 8 a.m. dose was borrowed.

2. June 3, 2011 staff interview with a Registered Nurse 3rd Floor stated the practice of borrowing medications was a common occurrence for 4 residents, involving Fentanyl patches. Laura noted the borrowing originated because the residents" patches were not re-ordered.

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 medications are administered to residents as prescribed., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following subsections:

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 sayants :

1. As per the Glengarry Bath List, an identified resident was scheduled to receive a tub bath each Monday and Thursday. According to the Resident Flow Sheet, the resident was provided a bath on Monday, May 2nd and a shower on Monday, May 9th. No bath/shower was provided on the scheduled Thursday May 5th, indicating the resident was only provided one bath, over a 1 week period. In addition, according to the Resident Flow Sheet, the resident was provided a bath on Thursday May 12th and Friday May 20th. No bath was provided on the scheduled Monday May 16th, indicating the resident was only provided one bath, over a 1 week period. The resident's plan of care did not contraindicate a minimum of two baths per week.

2. As per the Glengarry Bath List, an identified was scheduled to receive a tub bath each Monday and Thursday. According to the Resident Flow Sheet, the resident was provided a bath on Monday, May 9th and on Monday, May 16th. No bath was provided on the scheduled Thursday May 12th, indicating the resident was only provided one bath, over a 1 week period. The resident's plan of care did not contraindicate a minimum of two baths per week.

3. As per the Glengarry Bath List, an identified resident was scheduled to receive a tub bath each Sunday and Thursday. According to the Resident Flow Sheet, the resident was provided a bath on Thursday, May 5th and on Thursday, May 12th. No bath was provided on the scheduled Sunday May 8th, indicating the resident was only provided one bath, over a 1 week period. In addition, according to the Resident Flow Sheet, the resident was provided the next bath on Thursday, May 19th. Again, no bath was provided on the scheduled Sunday May 15th, indicating the resident was only provided one bath, over a 1 week period. The resident's plan of care did not contraindicate a minimum of two baths per week.

4. As per the Glengarry Bath List, an identified resident was scheduled to receive a tub bath each Monday and Friday. According to the Resident Flow Sheet, the resident was provided a bath on Monday, May 2nd and on Monday, May 9th. No bath was provided on the scheduled Friday May 6th, indicating the resident was only provided one bath, over a 1 week period. In addition, according to the Resident Flow Sheet, the resident was provided a shower on Friday, May 13th and bath on May 23rd. No bath/shower was provided on the scheduled Monday May 16th or Friday May 20th indicating the resident was only provided one bath, over a 9 day period. The resident's plan of care did not contraindicate a minimum of two baths per week.

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 all residents of the home are bathed, at a minimum, twice a week, to be implemented voluntarily.

Issued on this 9th day of June, 2011

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

Amanda Nia

L Thompson