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 sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Mar 20, 2019	2019_761733_0004 (A1)	006317-18, 010369-18, 015212-18, 028187-18	Critical Incident System

Licensee/Titulaire de permis

Corporation of the City of Cornwall
360 Pitt Street CORNWALL ON K6J 3P9

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

Amended by MARK MCGILL (733) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

No changes made.

Issued on this 20th day of March, 2019 (A1)

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

Original report signed by the inspector.

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Ministry of Health and Long-Term Care

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

Amended by MARK MCGILL (733) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 26, 28, March 1, 4, 5, 6, 7, 2019

Log 006317-18 (CI: M529-000008-18) and log 010369-18 (CI: M529-000012-18) are related to resident to resident physical abuse.

Log 015212-18 (CI: M529-000017-18) is related to staff to resident verbal abuse.

Log 028187-18 (CI: M529-000027-18) is related to falls.

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Administrator, Personal Support Workers, Registered Nurses, Registered Practical Nurses, Health Care Aides. The inspectors also reviewed residents' health care records, home policies and procedures, staff work schedules, observed resident common areas, and observed the delivery of resident care and services, including resident-staff interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of the original inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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	Légende 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that every licensee of a long-term care home shall protect residents from abuse by anyone.

A Critical Incident System (CIS) report indicated that verbal staff to resident abuse of resident #003 occurred during a specified date. Resident #003's Substitute

Decision Maker (SDM) had installed a video camera in resident #003's room. The SDM contacted the nursing home and alleged to Registered Nurse (RN) #101 that Health Care Aid (HCA) #106 was verbally abusive to resident #003.

Inspector #622 reviewed the Ministry of Health and Long-Term Care Emergency pager which stated that RN #107 contacted the emergency pager and alleged that HCA #106 verbally abused resident #003.

Inspector #622 reviewed progress notes for a specified date which indicated that RN #101 received a telephone message from resident #003's SDM requesting to be called back. RN #101 contacted resident #003's SDM and was informed that HCA #106 had been verbally abusive to resident #003 after lunch that day. RN #101 notified the Administrator and received direction to contact the Ministry of Health and Long Term Care.

Inspector #622 reviewed the Employee Corrective Action Document completed by the administrator which indicated that after meeting with resident #003's SDM and viewing the camera recordings from the specified date there was clear evidence of verbal abuse of resident #003 through degrading and some scolding by HCA #106. The document further indicated that the Administrator pointed out to HCA #106 that although meaning well, their approach was inappropriate.

Inspector #622 reviewed the licensee's investigation notes from a meeting between the Administrator and resident #003's SDM. The Administrator documented in review of the video footage from the specified date supplied by resident #003's SDM, HCA #106 was overheard saying discouraging comments that are classified as verbal abuse.

During an interview with inspector #622, resident #003's SDM stated they had a camera installed in resident #003's room which picks up sound and picture. The

SDM said they had reviewed the video footage from the camera in resident #003's room and noted on a specified date that HCA #106 took resident #003 to the washroom and the resident had been incontinent of stool. The SDM stated that HCA #106 said to resident #003, you did it again, this is too much work, this is too much, we don't like doing this, we don't like cleaning this up.

The SDM stated that they received a call from the Administrator that same evening after making their complaint and met with them to review the video the next morning. The SDM stated after viewing the video the Administrator stated this was clearly elder abuse and that they would take care of the concern.

During an interview with inspector #622, the Administrator stated they met with resident #003's SDM the morning after the incident of staff to resident abuse of resident #003 occurred. The Administrator stated the video footage of the staff to resident abuse of resident #003 showed HCA #106 talking to and treating resident #003 in a demeaning way and at one point appeared like they were scolding resident #003 about toileting and being incontinent. The Administrator stated that the investigation outcome related to the incident of staff to resident verbal abuse between HCA #106 and resident #003 on a specified date was in their opinion verbal abuse.

Therefore, the licensee has failed to protect resident #003 from verbal abuse by HCA #106. [s. 19. (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 that ensures residents are protected from abuse by anyone and ensures that residents are not neglected by the licensee or staff., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with.

A Critical Incident System (CIS) report indicated that verbal staff to resident abuse of resident #003 occurred on a specified date. Resident #003's Substitute Decision Maker (SDM) had installed a video camera in resident #003's room. The SDM contacted the nursing home and reported that Health Care Aide (HCA) #106 was verbally abusive to resident #003. The CIS report did not indicate that police had been notified.

A review of the nursing home's Resident Non-Abuse policy #MM-0704-08 - revised August 2018 indicated on page 3 of 5 under the heading "Mandatory Staff Reporting – Investigative Procedure" #4. The supervisor and or Director of Care/Administrator/Designate will contact the family/power of attorney of parties in the incident and the police.

A review of the progress notes on PointClickCare on the specified date and time indicated that there was no documentation related to police notification for the incident of staff to resident verbal abuse of resident #003.

During an interview with inspector #622, the Administrator stated that the outcome of the investigation related to the allegation of staff to resident #003 verbal abuse by HCA #106 on the specified date was in their opinion verbal abuse.

During an interview with inspector #622, Director of Care (DOC) #103 stated that the nursing home's policy states that any type of abuse has to be reported to the Ministry of Health and Long-Term Care and the police. DOC #103 further stated that the police had not been notified for the incident of staff to resident #003 verbal abuse which occurred on the specified date.

Therefore, the licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with. [s. 20. (1)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to immediately report the suspicion of abuse of a resident by anyone and the information upon which it was based to the Director.

A CIS Report was submitted to the Director regarding the abuse of resident #002 by resident #001.

A review of the CIS report indicates that the CI date and time was a specified date and time. The date and time the CI was first submitted to the Director was the next day.

In an interview with Director of Care #103 with Inspector #733, they indicated that staff should have called the incident in using the MOHLTC after-hours pager.

Therefore, the Director was not immediately notified of this incidence of abuse of a resident. [s. 24. (1)]

Issued on this 20th day of March, 2019 (A1)

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

Original report signed by the inspector.