Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection 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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 5, 2019	2019_583117_0038	004806-18, 009289-18, 016610-18, 017487-18, 020797-18, 026382-18, 026688-18, 002401-19, 006314-19	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

LYNE DUCHESNE (117), LISA KLUKE (547)

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): This inspection was conducted on the following date(s): June 10, 11 ,12, 13, 14, 17, 18, 19, 20, 21 as well as July 3, 4 and 5, 2019

This inspection included nine critical incident reports (CIR):
• CIR #M529-000019-18 (Log 017487-18), CIR #M529-000025-18 (Log 026688-18) both related to allegations of staff to resident abuse.
• CIR #M529-000024-10 (Log 026382-18), CIR #M529-000007-19 (Log 006314-19),CIR #M529-000022-18 (Log 020797-18) and CIR #M529-000006-18 (Log 004806-18) related to allegations of resident to resident abuse.
• CIR #M529-000001-19 (Log 002401-19), CIR #M529-000009-18 (Log 009289-18) and CIR #M529-000015-18 (Log 016610-18) related to falls that caused injury whereby residents were taken to hospital and which resulted in significant change in health status.

Complaint inspection #2019_621547_0001 was conducted concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), an Activity aide, a housekeeper, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

In addition, the inspector reviewed resident health care records, the Licensee's Least Restraint and Resident Non-Abuse policies and procedures, observed the resident care environments, resident to resident and staff to resident interactions and resident care.

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

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

- **3 WN(s)**
- **3 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. 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 resident #004. (Log # 017487-18)

Resident #004's plan of care indicated the resident wandered the home daily and was ambulatory with supervision. The resident wanders all day and will start to lean to one side when fatigued. The resident was known to wander frequently during the night.

Inspector #547 observed resident #004 on June 12 and 13, 2019 to be seated in a tilt style wheelchair.

Personal Support Worker (PSW) #113 and Registered Nurse (RN) #114 indicated the wheelchair belonged to the resident for rest periods to prevent falls.

RN #114 reviewed the resident's plan of care and indicated the resident's wheelchair was not identified as a mobility device nor was the reason for it's use identified as required to set out clear directions to nursing staff. [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 set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of abuse or neglect investigations were reported to the Director. (Logs # 004806-18, # 017487-18, # 020797-18 and # 026382-18)

On a specified day in 2018, the Licensee reported an incident (#M526-000006-18) of alleged resident to resident abuse. The incident was reported and investigated as required.

On a specified day in 2018, the Licensee reported an alleged incident (#M526-000019-18) of improper/incompetent treatment of a resident that results in harm or risk to a resident. The incident was reported and investigated as required.

On a specified day in 2018, the Licensee reported an incident (#M526-000022-18) of alleged resident to resident abuse. The incident was reported and investigated as required.

On a specified day in 2018, the Licensee reported an incident (#M526-000024-18) of alleged staff to resident abuse. The incident was reported and investigated.

On July 3, 2019 the Director of Care indicated to inspector #547 that the long-term care home's investigations for these Critical Incident Reports (CIR) were completed, however the investigation results or actions taken as a result for these residents were not reported to the Director as required by this section. [s. 23. (2)]

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 results of abuse or neglect investigations were reported to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #005 was not restrained by the use of barriers, locks or other devices or controls from leaving a room or any part of the home, including the grounds of the home or from entering part of the home generally accessible to other residents. (Log # 026688-18)

On a specified day in 2018, PSW #107 entered resident #005's bedroom during initial rounds of the resident's rooms and observed resident #005 awake in bed trying to get out of bed. Resident #005's foot of the bed was raised, the half rails located at the middle of each side of the bed were engaged, and the resident's bedside table was pushed up against the head of the bed and a chair was pushed up against the head of the bed on the other side. Resident #005 was unable to exit the bed.

Resident #005's plan of care indicates that the resident was a wanderer and was cognitively impaired. Resident #005's assessment for bed rails identified on logo above the resident's bed indicated no rails used for the resident's bed as part of the resident's plan of care.

On June 14, 2019 PSW #107 reported to inspector #547 that the resident was unable to

get out of bed on the morning this incident was observed. PSW #107 indicated the resident's bed rails were engaged, however the resident was not supposed to have rails in use when in bed. Resident #005's foot of the bed was observed elevated in high position. The resident's bedside table and sitting chair were positioned up against the bed. PSW #107 reported the room furniture was not usually positioned against the bed and that these were moved. PSW #107 indicated the resident was frustrated as trying to get up and could not due to the position the bedrails and furniture. PSW #107 indicated the resident is known to wander and the plan of care indicated to allow the resident to wander throughout the resident's home area.

The Administrator met with PSW #106 who worked the shift with resident #005 prior to PSW #107's observation on a specified day in 2018. PSW #106 indicated having cared for resident #005 during their shift. PSW #106 indicated the resident wandered quite a bit during the shift, in and out of the bedroom and required assistance to return the resident to bed. PSW #106 indicated the resident complained about sore lower legs that were swollen and elevated the resident's foot of the bed to the resident's comfort level. PSW #106 indicated the resident kept looking for eye glasses and placed the bedside table next to the resident's bed in order to reach these eye glasses. PSW #106 indicated both rails were engaged on the resident's bed that night and was not aware that the rails were not supposed to be engaged on either side for this resident. PSW #106 indicated not having seen the bed rail logo at the head of the resident's bed that night.

As such, resident #005 was restrained by the use of barriers such as bedside table and chair and devices such as bed rails on each side of the bed and elevated foot of the bed, which then made the resident unable to exit the bed and room. [s. 30. (1) 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 no resident of the home is restrained by the use of barriers, locks or other devices or controls from leaving a room or any part of the home, including the grounds of the home or from entering part of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36, to be implemented voluntarily.

Issued on this 6th day of September, 2019

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

Original report signed by the inspector.