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

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
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Public Copy/Copie 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
Nov 28, 2019	2019_618211_0022	018259-19	Complaint

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

JOELLE TAILLEFER (211)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 10, 11, 15, 16, 17, 24, 25, 29, 2019

Complaint Log #018259-19 related to the following:
-24-hour Registered Nurse coverage and,
-Any locked on bedrooms can be readily released from the outside in an emergency.

During the course of the inspection, the inspector(s) spoke with Administrator, the Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Department Secretary, Maintenance Staff, Payroll Coordinator and Personal Support Workers (PSWs).

In addition, the inspector reviewed residents' health care records, the licensee's Least Restraint Policy, the Workforce TeleStaff, registered nursing schedule of a specified period of time, licensee's memo, and observed the resident care environments.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulation.

Glen-Stor-Dun Lodge has a capacity of 132 beds and their master rotation are designed that Registered Nurses are working mostly twelve hours shift.

On an identified date, the Ministry of Long-Term Care received concerns by the Infoline, there was no Registered Nurse overnight and a new Registered Practical Nurse was responsible of the home. Moreover, it was happening frequently that there was no Registered Nurse in the building.

On an identified date, Inspector #211 reviewed the licensee's Workforce TeleStaff Roster Reports and it was determined that the licensee did not have a Registered Nurse (RN) on duty and present in the home for seven night shifts within two months.

In an interview with the Department Secretary on an identified date, stated that their Master Schedule indicated that the home must have one RN and one RPN present in the building during the night shift. However, there was occasions when they were unable to replace an RN for a night shift and they called a second RPN to be present in the home to replace the RN.

In an interview with the DOC on an identified date, confirmed that there was occasions, especially during the night shift, where at least one RN who was both an employee of the licensee and a member of the regular nursing staff of the home was not on duty and present in the home.

The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home during the above dates and times within two months. [s. 8. (3)]

Additional Required Actions:

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

WN #2: 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 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.

Specifically, the licensee has failed to ensure that any locks on bedrooms have been designed and maintained so they can be readily released from the outside in an emergency situation as indicated under O.Reg 79/10, s.9 (1) 4. Consequently, resident #001 was locked inside their bedroom and resident #002 was locked outside of their bedroom.

On an identified date, the MLTC received concerns related to a resident that was locked out all night from their bedroom because there was no key available to open the bedroom 's door. There was another incident, where a resident was locked inside their bedroom.

In an interview with PSW #103 on an identified date, stated that all bedroom doors has a

lock system, and the use of a key was the only way to lock or unlock a bedroom doors. The residents are unable to lock their own bedroom door from inside their room. All the resident's bedrooms are kept unlocked, unless requested by the resident when they are leaving the unit or the home. Residents #003, #004 and #005 were some of the residents requesting to have their bedroom's door closed and locked when leaving the unit. PSW #103 revealed that there was four PSWs working during the day shifts on that identified unit, but there was only one PSW having a key to unlock the resident's bedroom door. The other staff carrying a key on that identified unit were the RPN and the housekeeping staff.

In an interview with RN #107 on an identified date at 1600 hours, stated having the master key to lock and unlock all resident's bedroom's door in the building. The housekeeping staff was also carrying a key. However, each unit has their own key and they are keeping them either in the nursing station or their medication room.

In an interview with PSW #112 on an identified date, indicated that they were closing and locking the resident's bedroom doors during meal times since resident #010 was entering the other residents' bedroom. PSW #112 stated that resident #001's bedroom door was locked when the resident was inside the room. When resident #001 was brought in the dining room, they closed and locked the resident's bedroom door. After meal time, resident #001's bedroom door was unlocked. Unfortunately, when the key was pulled out from the lock, the bedroom's door became locked. PSW #112 stated the resident's door was closed before leaving the unit. Only one PSW who left the unit for break had the key to unlock the residents' bedroom door. Consequently, resident #001 was locked inside the room for several identified minutes.

In an interview with PSW #115 on an identified date, stated that only RN working during the night shifts has the key to unlock the residents' bedroom door. PSW #115 stated that once, resident #002 was locked outside of their bedroom for several identified hours. RN #114 was unable to unlock resident #002's bedroom door and the resident stayed sleeping on a chair or the love seat. During that night, resident #002 tried to enter their bedroom to sleep in their bed and the resident's bedroom door was unlocked only in the morning with a different key.

In an interview with the Maintenance staff on an identified date, stated that they were aware that there was a problem with the lock of the resident's bedroom doors. The teeth on the keys become worn off over a period of time or the lock system of the bedroom doors become loose and need tighten and being clean.

In an interview with the DOC on an identified date, stated that the incident was not reported to them when resident #002 was locked outside of the bedroom.

The licensee has failed to ensure that no resident of the home was restrained with a lock, when;
- resident #001's bedroom door was locked and prevented the resident from leaving the bedroom and,
- resident #002's bedroom door was locked and prevented the resident from entering the bedroom. [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 entering or leaving their bedroom., to be implemented voluntarily.

Issued on this 9th day of December, 2019

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JOELLE TAILLEFER (211)
Inspection No. / No de l'inspection :	2019_618211_0022
Log No. / No de registre :	018259-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 28, 2019
Licensee / Titulaire de permis :	Corporation of the City of Cornwall 360 Pitt Street, CORNWALL, ON, K6J-3P9
LTC Home / Foyer de SLD :	Glen-Stor-Dun Lodge 1900 Montreal Road, CORNWALL, ON, K6H-7L1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Steven Golden

To Corporation of the City of Cornwall, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall be compliant with s. 8. (3) of the LTCHA.
Specifically, the licensee of the long-term care home shall ensure that a least one registered nurse who is an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations

Grounds / Motifs :

1. The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulation.

Glen-Stor-Dun Lodge has a capacity of 132 beds and their master rotation are designed that Registered Nurses are working mostly twelve hours shift.

On an identified date, the Ministry of Long-Term Care received concerns by the Infoline, there was no Registered Nurse overnight and a new Registered Practical Nurse was responsible of the home. Moreover, it was happening frequently that there was no Registered Nurse in the building.

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In an interview with the DOC on an identified date, confirmed that there was occasions, especially during the night shift, where at least one RN who was both an employee of the licensee and a member of the regular nursing staff of the home was not on duty and present in the home.

The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home during the above dates and times within two months. [s. 8. (3)] (211)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Dec 31, 2019

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 28th day of November, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Joelle Taillefer

Service Area Office /
Bureau régional de services : Ottawa Service Area Office