Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Feb 18, 2020	2020_618211_0005	022202-19, 023313-19	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

JOELLE TAILLEFER (211)

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): January 30, 2020 and February 3, 4, 2020.

This inspection included the following:
-Log 022202-19 related to falls that caused injury whereby residents were taken to the hospital which resulted in significant change in health status.
-A complaint follow-up Log # 023313-19 related to 24-hour Registered Nurse coverage.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Resident Services Supervisor, the Physiotherapist, the Recreologist, the Secretary, a Registered Practical Nurse (RPN), and Personal Support Workers (PSWs).

In addition, the inspector reviewed residents' health care records including the head injury routine, 24 Hour Care-Resident Flow Sheet, the Risk Management/post-fall assessment, Physician orders, Physician medication reviews, Assessment Form for Lifts and Transfer, Laboratory results, referral for physiotherapist services, Fall Prevention policies and procedures, the Workforce TeleStaff Roster Reports, the registered nursing schedule of a specified period of time and observed the resident care environments and staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #001	2019_618211_0022	211

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is reassessed, and the plan of care reviewed and revised at any other time when, the resident's care needs change or care set out in the plan is no longer necessary.

On an identified date, the Ministry of Long-Term Care received a Critical Incident Report related to resident #001's fall on that date and was sent to the hospital. The resident sustained an injury.

Review of resident #001's health care records documentations were as followed:
-Two days later, the resident returned from the hospital. The resident's mobility at the time was to be transferred with two persons assist and needed to be closely monitored to prevent independent transfers. The resident was found walking in the room attempting to go to the bathroom. The resident was given a specific device.
-The next day, they noted that the resident was forgetful at times and needed to be seated back several times.
-Three days later, they observed the resident standing, tripping and falling from an identified device.
-The next day, the resident's mobility was weight bearing as tolerated with one-person assistance using a specific device. The goal was to improve the resident's gait.
-The following day, an identified device was placed on resident's mobility equipment and the resident's care plan was updated to reflect this change.
-Six day later, the resident was seen by staff to remove the safety device and turning it off.

-Three days later, the resident removed the safety device from an identified equipment and was found on the toilet.
-Six days later, the resident walk with one-person supervision and had a steady gait.

Review of resident #001's current plan of care under the focus "Risk for fall" indicated that the resident had an identified safety device and to ensure that the identified device was attached from the resident to the equipment at all times.

In an interview with RPN #104 on an identified date, stated that the resident didn't have the specified safety device as the resident no longer needed the identified equipment.

In an interview with the Supervisor of Resident Services-Nursing on an identified date, acknowledged that resident #001's current plan of care was not updated to reflect that the specified safety device was no longer used as a fall prevention for the resident.

The licensee has failed to ensure that the resident was reassessed, and the plan of care reviewed and revised when the resident's care needs set out in the plan was no longer necessary. [s. 6. (10) (b)]

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 resident was reassessed, and the plan of care reviewed and revised when the resident's care needs set out in the plan was no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, r. 30. (1), the licensee was required to ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation.

Specifically, the licensee did not comply with the Policy # DM3-0501-78 “Fall Prevention Policy, Procedure, Post-Fall and Evaluation” put in place on an identified date and year that indicated as a Post Fall Management, the interdisciplinary team will:
4. modify the plan of care and put a bedside logo (transfer) as indicated.
5. place a star on the resident name plate, as per falling star program (policy #DM3-0509 -13) and ensure the leaf is up to date on the white board in residents’ room.

Review of resident #001’s plan of care indicated that the resident was at risk for falls characterized by history of falls, injury and multiple risk factors.

Review of resident #001’s health care records indicated that the resident had several falls in the home since the admission.

On an identified date, Inspector #211 observed resident #001 lying in bed without side rails. As a fall prevention, a safety piece of fabric was placed on the floor beside the bed.

In an interview with the Administrator on an identified date, agreed that there were no instructions in the resident’s room that indicated that the resident was at risk for fall.

In an interview with the Supervisor of Resident Services-Nursing on an identified date, stated that the Falling Leaf was not in the resident’s room because the resident was not a high risk for fall and the resident didn’t have a fall for the past three months. However, the Supervisor of Resident Services-Nursing acknowledged that since the resident’s plan of care indicated that the resident was a risk for fall, a Falling Leaf should have been placed in the resident’s room.

The licensee failed to ensure to comply with their policy “Fall Prevention Policy, Procedure, Post-Fall and Evaluation” as indicated their Post Fall Management that the interdisciplinary team will:
4. modify the plan of care and put a bedside logo (transfer) as indicated.
5. place a star on the resident name plate, as per falling star program (policy #DM3-0509 -13) and ensure the leaf is up to date on the white board in residents ‘room. [s. 30.]

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 where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy and procedure, the procedure was complied with, to be implemented voluntarily.

Issued on this 26th day of February, 2020

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

Original report signed by the inspector.