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
Sep 2, 2020	2020_809733_0007	007409-20, 007478-20, 008041-20, 008354-20, 008970-20, 009406-20, 014300-20, 014919-20, 014940-20	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

MARK MCGILL (733), EMILY BROOKS (732)

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): August 5, 6, 7, 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, 24, 2020

Log 007409-20, log 009406-20 and log 014919-20 are related to falls.
Log 007478-20, log 008041-20, log 008354-20, log 008970-20 and log 014940-20 are related to alleged abuse and responsive behaviours.
Log 014300-20 is related to an unexpected/sudden death of a resident.

During the course of the inspection, the inspector(s) spoke with The Supervisor of Resident Services -Nursing, the Director of Care, Registered Practical Nurses (RPN), Registered Nurses (RN) and Personal Support Workers (PSW).

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

During the course of this inspection, Non-Compliances were issued.
- **2 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 resident #002 and resident #003 were protected

from abuse from anyone.

Sexual abuse as defined in Ontario Regulation 79/10 states that it consists of any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A Critical Incident Report (CIR) was submitted to the Director that described the alleged sexual abuse of resident #002 by resident #001. The CIR indicated that resident #002 was found in resident #001's room by PSW #102 with their seat belt undone, sweater off, and undershirt raised up and resident #001 was touching resident #002 inappropriately.

Resident Services Supervisor - Nursing indicated that resident #002 did not have the capacity to consent and would not be able to remove their own restraint.

PSW #102 described that they opened resident #001's room door and found resident #002 sitting with resident #001 standing over them. PSW #102 described that resident #002's shirt was above their head and tucked behind their neck, something that they would not be capable of doing, and that resident #001 was touching resident #002 inappropriately. PSW #102 said they separated the residents and removed resident #002 from resident #001's room and indicated that resident #002 was upset at the time.

Record review and staff interviews indicated that interventions were put in place after this incident, however, three days later, a subsequent CIR was submitted that described the alleged sexual abuse of resident #003 by resident #001.

The CIR described that staff entered resident #003's room and that resident #003 was sitting in their chair as resident #001 was standing in front of them. The CIR described that resident #003 stated that resident #001 touched them inappropriately and that resident #001 asked them to touch them inappropriately and they did.

Resident Services Supervisor - Nursing indicated that resident #003 did not have the capacity to consent.

PSW #101 told Inspector # 732 that on the day of the incident, they were walking down the hallway and noticed resident #003 sitting in their room in their recliner by their window, and resident #001 standing over them with their back towards the door with their pants down. Resident #003 told PSW #101 that resident #001 entered their room uninvited and asked them to touch them inappropriately. PSW #101 described resident

#003 as fearful and scared when talking to them after the incident.

Approximately one week later, another CIR was submitted that described a second incident of alleged sexual abuse of resident #003 by resident #001. RPN #103 told Inspector #732 that resident #003 was tearful in their room and was having difficulty sleeping. The alleged resident to resident sexual abuse was investigated by the Licensee and it was determined that no abuse occurred and resident #003 was recalling the previous incident of sexual abuse from resident #001.

In conclusion, the licensee has failed to ensure that both resident #002 and resident #003 were protected from abuse from resident #001. [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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of an unexpected or sudden death of a resident.

A critical incident was submitted by the licensee informing the Director about the unexpected death of resident #004. The CIR was submitted two days after the incident occurred. In an interview with Inspector 733, RPN #115 confirmed that the critical incident was submitted two days after the incident occurred as they spent the two days information gathering and only after this did they determine that the Director should be notified.

The licensee failed to immediately inform the Director regarding the unexpected death of resident #004. [s. 107. (1) 2.]

Issued on this 22nd day of October, 2020

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

Original report signed by the inspector.