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**

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## Public Copy/Copie du rapport 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 12, 2021 | 2021_809733_0016 | 003554-21, 004807-21, 007344-21, 010293-21, 010807-21, 011510-21, 011697-21 | 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), JANET MCPARLAND (142)

## 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): September 1, 2, 8, 9, 10, 16, 17, 21, 22, 23, 24, 27, 28, 29, October 1, 2021**

**Log 011697-21 (CIR: M529-000015-21), log 011510-21 (CIR: M529-000014-21), log 004807-21 (CIR: M529-000004-21) were related to abuse and neglect.**
**Log 010293-21 (CIR: M529-000012-21), log 007344-21 (CIR: M529-000008-21) , log 003554-21 (CIR: M529-000003-21) were related to responsive behaviours.**
**log 010807-21 (CIR: M529-000013-21) was related to the incompetent treatment of a resident.**

**During the course of the inspection, the inspector(s) spoke with Administrator, Nurse Practitioner/Acting Director of Care, Personal Support Workers (PSWs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Behavioural Support Ontario (BSO), Support Services Supervisor, Resident Services Supervisor - Nursing, Infection Prevention and Control (IPAC). The inspector also observed resident environments including resident rooms and common areas, observed the provision of care to residents and reviewed records. Infection Prevention and Control practices and cooling requirements (air temperatures in the home) were also reviewed.**

**The following Inspection Protocols were used during this inspection:**
**Infection Prevention and Control**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**
**Safe and Secure Home**

**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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 O.Reg 79/10, s. 21. Air temperature**

**Specifically failed to comply with the following:**

**s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:**
**1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).**
**2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).**
**3. Every designated cooling area, if there are any in the home. O. Reg. 79/10, s. 21 (2).**

**s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to measure and record specified air temperatures in the home

The home was required to measure and record specific temperatures starting May 15, 2021. The home did not begin measuring and recording these temperatures until June 23, 2021. According to the Support Services Supervisor, the home needed additional time in order to establish their temperature monitoring system. [s. 21. (2)]

2. According to a review of temperature logs that began on June 23, 2021, the last reading that was taken on any given day was 1400 hours. A further review revealed that no readings were taken on weekends. Support Services Supervisor confirmed to the inspector that readings were not taken at these times due to having no staff available to record the temperatures.

Sources: Review of temperature logs, interview with Support Services Supervisor [s. 21. (3)]

***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 temperatures are measured and documented at least once every evening or night and on weekends, to be implemented voluntarily.***

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**WN #2: 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 ensure that the person who had reasonable grounds to suspect that the abuse of a resident by anyone has occurred and immediately reported the suspicion and the information upon which it was based to the Director.

The incident of alleged physical and emotional abuse took place on a specified date. A registered staff member who learned of the abuse sent an email to Resident Services Supervisor - Nursing on the evening that the alleged abuse occurred. Resident Services Supervisor - Nursing only received the email the next morning when they arrived at work.

Therefore, immediate notification of the incident did not occur.

Source: Critical Incident M529-000004-21, Interview with Resident Services Supervisor - Nursing. [s. 24. (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 to ensure that the person who has reasonable grounds to suspect that the abuse of a resident by anyone has occurred immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. A PSW has failed to ensure that safe transferring techniques when assisting residents was used.

According to a resident's care plan, they are a two person assisted transfer. However, a PSW assisted this resident on their own by attempting to sit them up in their bed. It was at this time that an injury to the resident occurred. The PSW assisted the resident in a manner which was not consistent with a safe technique.

Sources: Critical Incident M529-000013-21, Interview with Resident Services Supervisor - Nursing. [s. 36.]

***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 safe transferring techniques when assisting residents are used, to be implemented voluntarily.***

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**Issued on this 15th day of November, 2021**

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

**Original report signed by the inspector.**