Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: October 30, 2023
Inspection Number: 2023-1551-0004
Inspection Type: Critical Incident
Licensee: Corporation of the City of Cornwall
Long Term Care Home and City: Glen-Stor-Dun Lodge, Cornwall

Lead Inspector	**Inspector Digital Signature**
Carrie Deline (740788)	Carrie E Deline Digitally signed by Carrie E Deline Date: 2023.11.15 10:01:30 -05'00'

Additional Inspector(s)
Kelly Boisclair-Buffam (000724)
Linda Harkins (126)
Cathi Kerr (641)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 18 - 22, 25 - 27, 2023
The following intakes were completed:

- Intake #00006968, CI#M529-000025-22 and Intake # 00008516, CI#M529-000027-22 and Intake # 00013502, CI #M529-000030-22 and Intake # 00015144, CI # M529-000008-23 and Intake # 00020654, CI # M529-000010-23 and Intake # 00091082, CI # M529-000034-23 and Intake # 00091080, CI # M529-000033-23 and Intake # 00091093, CI # M529-000036-23 and Intake # 00091089, CI # M529-000035-23 and Intake # 00091281, CI # M529-000042-23 and Intake # 00088635, CI # M529-000031-23 related to falls with injury.

The following intake(s) were inspected:

- Intake: #00015511 - M529-000031-22 Alleged improper/Incompetent treatment of a resident resulting in injury.
- Intake: #00017909 - M529-000002-23 Alleged neglect/improper treatment of a resident resulting in injury.
- Intake: #00019159 - M529-000007-23 Improper wound care.
- Intake: #00087136 - M529-000022-23 Alleged emotional abuse of residents by staff.
- Intake: #00088251 - M529-000027-23 Alleged physical abuse of resident to resident resulting in injury.
- Intake: #00088713 - M529-000032-23 Alleged neglect of resident by staff.
- Intake: #00091117 - M529-000037-23 Alleged physical abuse of resident to resident resulting in injury.
- Intake: #00092029 - M529-000045-23 Alleged staff to resident neglect.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a suspicion of Abuse or Neglect was immediately reported to the Director.

Part 1
Rationale and Summary
On a specific date in July of 2023 a resident was found by oncoming night PSW's sitting on the toilet still attached to a sling and lift. During an interview with staff who found the resident they were unable to identify to the inspector when management was made aware of the incident. This incident was not reported to the Director until seven days later. This alleged neglect was not immediately reported to the Director. Failure to immediately report alleged abuse or neglect delays investigation into the incident and taking appropriate action to ensure a safe and supportive environment for residents.

Sources:
Critical Incident Report (CIR) report, resident's progress notes, interviews with the Director of care, Registered staff, Education Coordinator, and PSW's .
[740788]

Part 2
Rationale and Summary
On a specific date in May 2023 a resident was found by oncoming night PSW's sitting on the toilet still attached to a sling and lift unattended. The CIR indicated that the supervisor was made aware and that

the DOC was made aware to start the investigation. This incident was not reported to the Director until seven days later. This alleged neglect was not immediately reported to the Director. Failure to immediately report alleged abuse or neglect delays investigation into the incident and taking appropriate action to ensure a safe and supportive environment for residents.

Sources:
Critical Incident Report (CIR) report, residents progress notes, interviews with the Director of care, Registered staff, Education Coordinator, and PSW's .
[740788]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that safe transferring techniques were used when assisting residents.

Part 1
Rationale and Summary
A record review of a resident indicated specific focused goals and interventions related to safe transfers which included the usage of the Maxi-Lift .

Upon observation of the resident's room, the Maxi-Lift transfer logo was posted in their room.

Staff members confirmed that the resident had been a Maxi-Lift transfer for over a year as they were unable to weight bear.

Staff acknowledged that on a specific date in January 2023, two staff members utilized a Sara-Lift to transfer the resident instead of a Maxi-Lift. The Sara-lift requires that the resident is able to weight bear and the resident is unable to do that and as a result the resident slid out of the lift causing injury to the resident.

By not following the plan of care related to transfers, the resident sustained an injury.

Sources:
Critical Incident Report (CIR); resident's health care record; interviews with the DOC, Registered Staff and PSWs; observation of resident.
[000724]

Part 2
Rationale and summary:
Inspector reviewed Critical Incident Report (CIR) which indicated that on a specific date in December 2022, a resident fell out of their wheelchair while being transported by a staff member. The staff member had independently lifted the resident from the floor back into the wheelchair without assistance of another staff or mechanical lift.

During interviews with the Inspector, the staff indicated that when a resident had fallen, they would follow the licensee's falls policy to assist the resident off the floor using two staff and a mechanical lift after assessment by a Registered staff member. Staff confirmed that the resident involved would require two staff for any transfer as one staff would be unsafe.

Failure to use safe transferring techniques by staff increased the risk to the resident.

Sources:
Critical Incident Report (CIR); resident's health care record; interviews with the DOC and PSWs; licensee's Falls Prevention and Management Program Policy.
[641]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg 246/22 s. 54 (2)

The licensee has failed to comply with their written policies related to Falls prevention and management.

In accordance with O. Reg 246/22 s. 11 (1) b the licensee is required to ensure that their Falls prevention and management policy and procedure is complied with.

Specifically, staff did not comply with their Falls prevention and management policy which states that

staff are to report any resident fall immediately to the nurse.

Rationale and summary:
The licensee's policy titled Falls Prevention and Management Program indicated staff are to report any incident of a resident found on the floor or resident fall immediately to the nurse.

Critical Incident (CIR) indicated that when the resident fell , they were independently lifted back into their wheelchair by a staff member. Staff did not report the fall or the independent transfer to their supervisor.

During interviews with Inspector, the Nursing Supervisor (NS) and DOC indicated that they were unable to find any documentation of an investigation having been completed related to this incident.

Failure to not complete the post fall assessment as per the Licensee's Falls Prevention and Management policy puts the resident at increased risk of a change in condition being discovered.

Sources:
CIR; resident's health care record; interviews with the DOC and NS, licensee's policy Zero Tolerance of Resident Abuse and Neglect Program.
[641]

WRITTEN NOTIFICATION: Staff retraining

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, s. 82 (4)

The licensee has failed to ensure that staff members have training on the long-term care home's policy to promote zero tolerance of abuse and neglect of residents annually.

In accordance with FLTCA s. 82 (2) 3 the licensee is required to ensure that staff receive training on the home's policy to promote zero tolerance of abuse and neglect of residents at orientation and specifically, as per O. Reg 246/22 s, 260 (1) this training must be completed annually.

Part 1
Rationale and Summary
A review of the education of the two staff who were involved in reported incidence, revealed that they had not received any education on the home's abuse and neglect policy since November of 2021.

During an interview with the Education Coordinator, it was confirmed that the expectation is to complete the education annually. The Education Coordinator confirmed that after review of the education documentation this was not complete.

By not ensuring staff have annual abuse and neglect training means staff may not be aware of requirements under the policy to promote zero tolerance of abuse and neglect.

Sources:
Staff education records and Interview with the Education Coordinator.
[740788]

COMPLIANCE ORDER CO #001 Licensee must investigate

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (ii)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall be compliant with FLTCA, 2021, s. 27 (1) (a) (ii).

Specifically, the licensee must:
1. Ensure that all alleged, suspected or witnessed reports of neglect are fully investigated.
2. Maintain documentation of the investigations, including who completed the investigation, interviews, findings, and any corrective actions taken.
3. The Administrator is to complete an audit of all alleged abuse or neglect incident investigations. The audits are to me completed for a minimum of one month, or until all staff are compliant with the process.
4.Maintain documentation of the audits, including when the audit was completed, who completed the audit, the findings and any corrective actions taken.

1.
The licensee has failed to ensure that every alleged, suspected or witnessed incident of neglect of a resident by staff, that is reported to the licensee is immediately investigated.

Rationale and summary:
Critical Incident Report (CIR) indicated that a resident was left in a sling on the toilet for an unknown length of time.

During interviews with the Inspector, the Director of Care (DOC) indicated that they were unable to find any documentation of an investigation having been completed related to this incident.

Failure to investigate the alleged incident of neglect may increase the risk of neglect to other residents in the home.

Sources:
CIR; resident's health care record; interviews with the DOC.
[740788]

2.
The licensee has failed to ensure that every alleged, suspected or witnessed incident of neglect of a resident by staff, that is reported to the licensee is immediately investigated.

Rationale and summary:
Critical Incident Report (CIR) indicated that the resident was left in a sling on the toilet unattended for an unknown length of time.

During interviews with the Inspector, the Director of Care (DOC) indicated that they were unable to find any documentation of an investigation having been completed related to this incident.

Failure to investigate the alleged incident of neglect may increase the risk of neglect to other residents in the home.

Sources:
CIR; resident's health care record; interviews with the DOC.
[740788]

3.
The licensee has failed to ensure that every alleged, suspected or witnessed incident of neglect of a resident by staff, that is reported to the licensee is immediately investigated.

Rationale and summary:
Critical Incident Report (CIR) indicated that a resident was not transferred with the proper lift , a Maxi-Lift , as indicated in their plan of care. The resident was transferred with the weight bearing Sara-Lift . The resident had been unable to weight bear and was settled on the floor by two staff members. As a result, the resident sustained an injury.
The two staff members reported the incident to nurse. The nurse assisted with the transfer of the

resident into their wheelchair with the Maxi-Lift and initiated an assessment of the resident for injuries.

During interviews with staff, it was confirmed that the resident had been unable to weight bear for a minimum of a year and was to be transferred with a Maxi-Lift.
Staff indicated in their interview that they do not remember who the two staff members involved were and there is no investigation notes of who was involved. The DOC indicated that they were unable to find any documentation of an investigation having been completed related to this incident and was not aware of the two staff members involved.

Failure to investigate the incident may increase the risk of neglect to other residents in the home.

Sources:
CIR, resident's health care records; and interviews with staff.
[000724]

This order must be complied with by December 18, 2023

COMPLIANCE ORDER CO #002 Skin and Wound Care

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall be compliant with O. Reg s. 55 (2) (b) (ii).
Specifically, the licensee must:

Ensure that residents with altered skin integrity receives immediate treatment and interventions.

To ensure this is done:
a. Complete a weekly audit of all residents that require wound treatment to ensure treatment is complete as per orders. The audits are to be completed for a minimum of one month.
b. Maintain documentation of the audits, including when the audits were completed, who completed the audits, the findings and any corrective actions taken.

Grounds:
The licensee has failed to ensure that a resident, who was exhibiting altered skin integrity, including skin breakdown and pressure injuries, received immediate treatment and interventions to reduce or relieve

pain, promote healing and prevent infection, as required.

Rational and Summary:
Inspector reviewed Critical Incident (CIR) which indicated that on a specific date in January 2023, a resident's wound had discharge and foul odour requiring a dressing change. The CIR indicated that the wound had first been noted 11 days prior to this date with no further documentation of this wound or treatment of the wound. The wound required further treatment in hospital.

During an interview with the Inspector, staff indicated that there was no indication that an assessment or wound care had been done on the wound for 11 days.
Inspector reviewed the resident's health care record, including progress notes and the electronic Medication Administration Record (e-MAR). The eMAR had documentation of daily treatment for the wound starting 14 days after first noting the wound.

Not completing wound care on the resident for eleven days placed the resident at increased harm and risk for complications and deterioration of the wound.

Sources:
CIR, resident's health care record, interviews with staff, Policy and procedures related to skin and wound care.
[641]

This order must be complied with by December 18, 2023

COMPLIANCE ORDER CO #003 Skin and Wound Care

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall be compliant with O. Reg s. 55 (2) (b) (iv).

Specifically, the licensee must:

Ensure that residents with areas of altered skin integrity are reassessed weekly by a member of the registered nursing staff, if clinically indicated, using a clinically appropriate assessment instrument specifically designed for skin and wound assessment.

To ensure this is done:
a. Complete a weekly audit of all residents where a weekly wound assessment is clinically indicated. The audits are to be completed for a minimum of one month, or until all staff are compliant with the process.
b. Maintain documentation of the audits, including when the audits were completed, who completed the audits, the findings and any corrective actions taken.
c. Conduct education on the licensee's Skin and Wound Program policies and the use of a clinically appropriate assessment instrument specifically designed for skin and wound assessments, with the Wound Care Champion and any other registered nursing staff designated to complete weekly wound assessments.
d. Maintain documentation of the education, including the names of the staff, their designation, training date, who provided the education and what was included in the education.

Grounds:
The licensee has failed to ensure that a resident, who was exhibiting altered skin integrity, including skin breakdown, and pressure injuries, was reassessed at least weekly by a member of the registered nursing staff, as clinically indicated.

Rational and Summary:
A review of the resident's health record indicated that a resident had a wound documented on a specific date in January 2023. The wound was not reassessed using a clinically appropriate skin and wound assessment tool for 11 days.

During an interview with Inspector, staff indicated that all open wounds should have a weekly assessment completed. The assessments of the wounds would be completed by either the registered nursing staff on the unit or themselves, when available. Staff confirmed that the resident's wound had not been reassessed for a period of 11 days in January 2023 as required.

The lack of weekly reassessments of the resident's wound posed a risk of harm to the resident as it allowed for further deterioration of the wound.

Sources:
CIR, resident's health care record including eMAR and progress notes, interviews with staff, Policy and procedures related to skin and wound care. [641]

This order must be complied with by December 18, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.