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: January 16, 2024	
Inspection Number: 2023-1551-0005	
Inspection Type: Critical Incident Follow up	
Licensee: Corporation of the City of Cornwall	
Long Term Care Home and City: Glen-Stor-Dun Lodge, Cornwall	
Lead Inspector Stephanie Fitzgerald (741726)	**Inspector Digital Signature**
Additional Inspector(s) Carrie Deline (740788) Polly Gray-Pattemore (740790) Anna Earle (740789)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 5, 6, 2023, and January 9, 10, 2024.

The following intake(s) were inspected:

- Intake: #00094563 - Follow-up #: 1 - FLTCA, 2021 - s. 6 (7) in relation to staff not complying with the written plan of care.
- Intake: #00094564 - Follow-up #: 1 - FLTCA, 2021 - s. 6 (10) (c) in relation to revisions to the written plan of care, when ineffective.
- Intake: #00094565 - Follow-up #: 1 - O. Reg. 246/22 - s. 35 (2) in relation to the licensee not having a written staffing plan.

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- Intake: #00094566 - Follow-up #: 1 - O. Reg. 246/22 - s. 147 (2) (a) in relation to ensuring all medication incidents were documented, reviewed and analyzed.
- Intake: #00094567 - Follow-up #: 1 - O. Reg. 246/22 - s. 53 (1) 1. in relation to head injury routine not being documented.
- Intake: #00094568 - Follow-up #: 1 - O. Reg. 246/22 - s. 132 (b) in relation to the use and maintenance of the emergency drug supply.
- Intake: #00096933 - M529-000049-23 - medication incident.
- Intake: #00096944 - M529-000051-23 Written complaint/response concerning the care of a resident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1551-0003 related to FLTCA, 2021, s. 6 (10) (c) inspected by Carrie Deline (740788)

Order #002 from Inspection #2023-1551-0003 related to O. Reg. 246/22, s. 35 (2) inspected by Polly Gray-Pattemore (740790)

Order #003 from Inspection #2023-1551-0003 related to O. Reg. 246/22, s. 53 (1) 1. inspected by Carrie Deline (740788)

Order #004 from Inspection #2023-1551-0003 related to O. Reg. 246/22, s. 132 (b) inspected by Stephanie Fitzgerald (741726)

Order #005 from Inspection #2023-1551-0003 related to O. Reg. 246/22, s. 147 (2) (a) inspected by Stephanie Fitzgerald (741726)

Order #006 from Inspection #2023-1551-0003 related to FLTCA, 2021, s. 6 (7) inspected by Anna Earle (740789)

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting and Complaints

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to immediately forward any written complaint that it receives concerning the care of a resident to the Director.

Rationale and Summary

On a specified day in August, a written complaint from a family member of a resident of the Long-Term Care Home (LTCH), was received by the LTCH via email by the Director of Nursing. It was forwarded to the Administrator, Nursing Supervisor, and Human Resources with recognition that it was received as a written complaint. This incident was not forwarded to the Director until 10 days later. This written complaint regarding care of a resident was not immediately forwarded to the Director. Failure to immediately forward any written complaint that is received concerning care of a resident delays investigation into the incident and taking appropriate action to ensure a safe and supportive environment for residents.

Sources:
Critical Incident System (CIS) report # M529-000051-23, record review, and interviews with the Nursing Supervisor #104.

[740788]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the

home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to ensure that the complaint response provided to a person who made a complaint shall included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman.

Rationale and Summary

A review of the CIS submitted on a day in September, indicated that a written complaint was received by the LTCH, 10 days prior. The LTCH responded to the complaint in writing, but did not provide the contact information for the Ministry or the ombudsman.

Interview with the Nursing Supervisor confirmed that the information had not been provided to the complainant.

Failure to provide the contact information could mean the complainant is unaware of the next steps to escalate the situation, this could impede the health, safety, and well-being of the residents.

Sources:

CIS M529-000051-23, LTCH complaint documentation, and interview with the Nursing Supervisor #104.
[740788]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 5.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital.

The licensee has failed to ensure that the Director was informed of a medication incident or adverse drug reaction in respect of which a resident is taken to hospital, within one business day.

Rationale and Summary
On a day in September, a CIS report was submitted to the Director in relation to a Medication Incident which occurred on a day in August, involving a resident not receiving routine medications.

A review of the resident's progress notes, shows the resident was first admitted to the home on a specified day in August, and was sent to hospital on the following day, to receive routine medication that was not available to the home.

During an Interview with the Administrator, it was confirmed that the incident occurred on a day in August, and was first submitted to the Director 10 business days after the incident occurred.

The risk associated with not informing the Director of medication incidents within one business day, is that it could delay the investigation or appropriate follow-up.

Sources: CIS # M529-000049-23, resident's progress notes on PCC, Interviews with Administrator #101. [741726]

WRITTEN NOTIFICATION: Administration of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that a drug was administered to the resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary:
On a specified day in September, a CIS report was submitted to the Director in relation to a Medication Incident which occurred on a day in August, involving a resident.

During a review of the resident's New Admission Order Form, 10 medications were noted to be ordered by the physician on the admission date.

A review of the resident's electronic Medication Administration Record (eMAR) for the month of August, shows the first date a routine medication was administered, was two days after the admission date.

During a review of the electronic progress notes for the resident, it was noted that the medications first arrived to the LTCH two days after the resident was admitted. There was no prior documentation to indicate the medications were administered prior to this date.

Inspector completed an interview with the Nursing Supervisor, where it was confirmed that the resident was admitted on a specified date in August, and the home did not receive the residents medication strip until two days later. The Nursing supervisor confirmed that the resident did not have their medication administered in accordance with the directions for use specified by the prescriber.

As a result of this non-compliance, the resident was at risk of experiencing adverse effects of a medication error.

Sources: CIS # M529-000049-23; resident's New Admission Order Form, eMAR (August, 2023), electronic progress notes; Interview with Nursing Supervisor #104.
[741726]