Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jan 25, 27, 30, Feb 1, 10, 17, 2012	2012_054133_0002	Critical Incident

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF CORNWALL
1900 Montreal Rd., CORNWALL, ON, K6H-7L1

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Supervisor of Support Services, the Supervisor of Resident Services, a Registered Nurse, a Registered Practical Nurse and a resident. The inspector also spoke with the home's contracted OTIS elevator technician and a Regional Supervisor with the Technical Standards & Safety Authority.

During the course of the inspection, the inspector(s) reviewed a Critical Incident Report, reviewed components of a resident's health care record related to the reported critical incident, reviewed the licence for the home's two passenger elevators and reviewed maintenance related documentation for the two passenger elevators. In the company of the Supervisor of Support Services, the inspector observed the time it took for both passenger elevator doors to close. The inspector also reviewed information provided by a Regional Supervisor of the Technical Standards & Safety Authority (TSSA) about elevator safety and reviewed a TSSA inspection report for an inspection conducted at the home on February 9, 2012.

The following Inspection Protocols were used during this inspection:

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (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 (4):

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.

2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.

3. A missing or unaccounted for controlled substance.

4. An injury in respect of which a person is taken to hospital.

5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. As per O. Reg 79/10, s. 107(3)4: The licensee failed to ensure that the Director was informed within one business day of an injury in respect of which a person is taken to hospital.

On a day in December 2011, an identified resident sustained an injury due to a fall that required them to be transferred to hospital for assessment. The resident fell while boarding one of the home's passenger elevators. The resident was speaking with a co-resident while standing in the path of the elevator door. The door began to close, the resident lost their balance and fell. The Director was notified two business days following the injury via a Critical Incident Report.

Issued on this 21st day of February, 2012

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

Jessica Lapensée