Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 27, 2013	2013_200148_0030	O-000757-13	Resident Quality Inspection

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

AMANDA NIXON (148), JANET MCPARLAND (142), LINDA HARKINS (126)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): August 12-16 and August 20-23, 2013, on site.

This inspection included two Critical Incidents.

In addition this inspection also included a Follow Up inspection, related to the issues of retaliation of January 2010.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Nutritional Manager, Supervisor of Support Services, Manager of Resident Services, Manager of Infection Control and Health & Safety, the home's Financial Analyst, Secretary, Nurse Practitioner, Registered Dietitian, Registered Nursing Staff, Pharmacy Technician, Kinesiologist, Housekeeping aids, Recreation assistant, Personal Support Workers (PSW), Food Service Workers, Family members and residents.

During the course of the inspection, the inspector(s) reviewed resident health records, staffing schedules, bathing records, documents related to the falls program, end of life protocol, documents related to mandatory training in the home, Resident Council and Family Council meeting minutes, documents related to the Infection Control Program, the Accommodation Agreement, the Purchase of Services Agreement, the Admission Information Package and the lawyer Certification of Model Accommodation Agreement. Several policies were reviewed including: Replacing Nursing Staff Policy #DM3-0508-03, Call in Procedure Part time/causal Staff Policy #MM-0808-09. Inspectors also observed meal service, medication administration, medication storage areas, recreational activities and resident care. In addition, the home's policy to promote zero tolerance of abuse and neglect, titled Resident Non-Abuse Policy #MM-0704-08 (including whistle-blowing protections, training requirements pertaining to prevention of abuse and neglect and mandatory reporting) was reviewed.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance
Admission Process
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Death
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Recreation and Social Activities
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.15 (2)(c), whereby the licensee did not ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

During this inspection it was observed on the 2nd and 3rd floor units that the finishing on the wood panelling of the lower walls in several resident common areas, including hallways and dining rooms was found to be in disrepair. Similarly, the finishing on the wood shelving found in the hallways near the entrance of resident rooms were also found to be in disrepair.

An interview with the home's Supervisor of Support Services indicated that the home is continuing to investigate options of repair and maintenance to this specialized material. [s. 15. (2) (c)]

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 home is maintained in a good state of repair as it relates to the wood finishing in resident common areas, to be implemented voluntarily.

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 failed to comply with LTCHA 2007, S.O. 2007 , c.8, s.24(1)2., whereby a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm immediately reported the suspicion and the information upon which it was based to the Director.

A review of Critical Incident #M529-000020-13 and interview with the home's DOC indicated that on a specified date a Physiotherapy Assistant and housekeeper observed Resident #18 react negatively to PSW Staff member #S20. When the Physiotherapy Assistant (PTA) and housekeeper spoke with the resident, the resident indicated that physical abuse had taken place. The PTA and housekeeper provided a report of the suspected abuse to the Manager of Resident Services several days later. The DOC was informed of the suspected abuse on a later date at which time an investigation was initiated. Reasonable grounds to suspect abuse were available to staff members of the home, however, the Director was not notified of the suspected abuse immediately. The home's investigation concluded that no abuse had occurred.

A review of Critical Incident #M529-000021-13 and interview with the home's DOC indicated that on a specified date, Resident #19 reported to a nurse that during a previous shift PSW Staff member #S21 had provided inappropriate care. The nurse called the DOC and reported the resident's claims. Staff member #S21 was replaced for the next scheduled shift. The home initiated an investigation which concluded that emotional abuse had occurred. Reasonable grounds to suspect abuse were available to staff members of the home, however, the Director was not notified of the suspected abuse immediately.

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 a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s.97(1)(b), whereby the licensee did not ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

A review of Critical Incident #M529-000020-13 and interview with the home's DOC indicated that on a specified date a Physiotherapy Assistant and housekeeper observed Resident #18 react negatively to PSW Staff member #S20. When the Physiotherapy Assistant (PTA) and housekeeper spoke with the resident, the resident indicated that physical abuse had taken place. The PTA and housekeeper provided a report of the suspected abuse to the Manager of Resident Services several days later. The DOC was informed of the suspected abuse on a later date at which time an investigation was initiated. Reasonable grounds to suspect abuse were available to staff members of the home. The home's investigation concluded that no abuse had occurred.

The Critical Incident submitted to the Director indicates that the resident's SDM was not notified of the suspected abuse. An interview with the home's DOC confirmed that the resident's SDM was not notified of the suspected abuse. [s. 97. (1) (b)]

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 resident's SDM is notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c. 8, s. 3 (1) 11. iv, whereby the licensee did not ensure that the resident's health information within the meaning of the Personal Health Information Protection Act, 2004 was kept confidential in accordance with that Act.

It was observed during the medication passes on August 20 and 21, 2013 that Registered staff placed multi-dose medication packages for residents which identified resident personal health information inclusive of names and name of medications into a garbage bag attached to the medication cart. When staff members #S10, #S11 and #S22 were questioned about this, they reported that garbage was disposed of with the regular garbage.

The Director of Care indicated that the home is working with the Pharmacist to implement a system in which the personal health information on the multi-dose medication package is destroyed prior to disposing of in the garbage. [s. 3. (1) 11.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee to comply with O.Reg 79/10, s.17(1)(b), whereby the licensee did not ensure that the resident-staff communication and response system is on at all time.

On August 15, 2013, Resident #10's call bell system was verified by Inspector #126. It was observed that the battery operated portable call bell (i.e. petite call bell) was clipped on Resident #10's walker and was not functioning at the time. Discussion with a PSW staff member indicated that it is usually the nurse that changes the battery of the portable call bell. Discussion with the Registered Practical Nurse Staff member #S22,indicated the batteries of these call bells are changed by the nurse when needed and that there is no system in place to monitor the need to change batteries in these call bells.

On August 8, 2013, it was documented in the progress notes of Resident #5 that the resident was upset at the beginning of shift because the portable call bell wasn't working. Resident #5 indicated to a staff member that she rang for an hour and was very tearful. [s. 17. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s.30(1)4., whereby the licensee did not ensure that for each organized program required under sections 8 to 16 of the Act and section 48 of the regulation, that a written record relating to each evaluation includes the date, the names of the persons who participated, a summary of the changes made, and the date that the changes were implemented.

Inspector #148 interviewed the managerial staff responsible for the Nursing and personal support services, Restorative care, Recreation and Social Activities, Dietary services and hydration, Medical Services, Religious and spiritual practices, Accommodation Services and Volunteer program.

It was determined that although the home has in place quality monitoring procedures, a written record relating to the evaluation of the above organized programs could not be provided that met the provisions of O.Reg 79/10 s.30(1)4.

It was noted that the home is currently in the process of conducting a formal evaluation of the Accommodation Program. [s. 30. (1) 4.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10, s.229. (10) 1, whereby the licensee did not ensure that each resident admitted to the home must be screened for tuberculosis (TB) within 14 days of admission.

Resident #17, was admitted on a specified date. A review of the resident's health record indicates that TB testing was not completed within 14 days of the resident's admission. [s. 229. (10) 1.]

2. The licensee failed to comply with O.Reg 79/10, s.229(10) 3., whereby the licensee did not ensure that residents must be offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedule.

An interview with the Manager of Infection Control reported to Inspector #126 that the home does not offer tetanus and diphtheria. [s. 229. (10) 3.]

Issued on this 27th day of August, 2013

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

Amanda Nej RD LTCH Inspector
And on behalf of: Janet McFarland
and Linda Harkins