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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 7, 2018	2018_702197_0015	014237-18, 015840-18	Critical Incident System

Licensee/Titulaire de permis

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 PATTISON (197)

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): July 9, 10(on-site), 11-13 (off-site), 2018

The following logs were inspected as part of this report:
log 014237-18 - the fall with injury and transfer to hospital of a resident
log 015840-18 - the fall and unexpected death of a resident

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Secretary, the Resident and Family Advisor, Registered Nurses, a Registered Practical Nurse and student and Personal Support Workers.

The inspector also reviewed a resident's health care record and the home's Fall Prevention Policy.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's plan of care set out clear direction to staff related to the trial of a falls prevention measure.

Resident #001 was identified in their most recent care plan as being at risk for falls. Resident #001 had falls on three specified dates in one month. Later that same month, the Resident and Family Advisor put a new falls prevention measure in place to trial for resident #001. The Resident and Family Advisor made a progress note that indicated they had phoned the resident's Power of Attorney (POA) to follow-up regarding the trial of the falls prevention measure and that the POA agreed to the trial. They noted that discussion was held related to the trial and monitoring the effectiveness and that follow-up discussions can be held.

During an interview with the Resident and Family Advisor, they stated that they told four Personal Support Workers (PSWs) on the evening shift on the day the falls prevention measure was put into place to trial. The Resident and Family Advisor stated that their expectation would have been that the PSWs share this information at shift change and that the Registered staff would have read the progress note that was made.

Resident #001 had a fall three days after the new falls prevention measure was put into place. Interviews were conducted with Registered Nurse (RN) #102 and PSW #104, who were working when the resident fell. Both staff members indicated they did not see the specified falls prevention measure in place at the time of the fall and they were not aware that it was being trialed for the resident.

RN #106 and RPN student #108, both familiar with resident #001’s care, stated that the specified falls prevention measure was discussed but that to their knowledge it had not been put into place.

The Director of Care was interviewed and indicated that the expectation would be that staff would have communicated the trial of the fall prevention measure at each shift change and that registered staff should be reading back in the progress notes to ensure they are aware of any changes to resident #001’s care.

Staff who provide direct care to resident #001 did not receive clear direction related to the use and trial of the specified fall prevention measure due to the following facts:

- Four staff members were not aware of the trial, including two that worked directly with the resident on the specified date when the resident last fell.
- The progress note written by the Resident and Family Advisor does not indicate that the fall prevention measure was put into place. [s. 6. (1) (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 residents' written plans of care set out clear direction to staff and others who provide direct care to the residents, to be implemented voluntarily.

Issued on this 7th day of August, 2018

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

Original report signed by the inspector.