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

Ottawa Service Area Office
347 Preston Street, Suite 420
Ottawa ON K1S 3J4
Telephone: 1-877-779-5559
OttawaSAO.moh@ontario.ca

Original Public Report

Report Issue Date November 17, 2022
Inspection Number 2022_1551_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Corporation of the City of Cornwall

Long-Term Care Home and City
Glen-Stor-Dun Lodge, Cornwall

Lead Inspector
Mark McGill (733)

Inspector Digital Signature
Mark J McGill
2022.11.17 11:44:14 -05'00'

Additional Inspector(s)
Sarah Stephens (740823)
Heath Heffernan (622)

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 15, 17, 18, 19, 23, 24, 25, 26, 29, 30, 31, September 1, 2, 6, 2022

The following intake(s) were inspected:

- Intake # 000405-22 (CIS # M-529-000002-22), Intake # 018143-21 (CIS #M529-000028-21) related to a potential improper transfer.
- Intake # 017349-21 (CIS #M529-000026-21), related to alleged staff to resident verbal abuse.
- Intake #021058-21/ (CIS #M529-000036-21), related to alleged staff to resident physical abuse.
- Intake # 002744-22/ (CIS #M529-000008-22) related to staff to resident alleged neglect.
- Intake # 010954-22/ (CIS #M529-000015-22), Intake #012389-22/ (CIS #M529-000018-22) related to alleged resident to resident sexual abuse.
- Intake # 013281-22 (Complaint) related to IPAC and care concerns.
- Intake # 020181-21 (CIS #M529-000034-21) related to responsive behaviours.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)

- Prevention of Abuse and Neglect
- Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION LICENSEE MUST INVESTIGATE, RESPOND AND ACT

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 23 (1) (a) (ii)

The licensee has failed to ensure that an incident of staff to resident #007 alleged neglect was immediately investigated.

Rationale and Summary

A Critical Incident System report (CIS) indicated that an incident of staff to resident #007 alleged neglect had occurred on a specified date.

The licensee investigation records indicated that the Director of Care (DOC) had received an email from a registered nurse (RN) alleging the neglect of a resident on a specified date. The documentation also stated that the Administrator interviewed a resident on a specified date and that there were no other prior documents to indicate that an investigation of the allegation had started.

On a specified date the DOC stated that the investigation was initiated on a later date, when the Administrator spoke with a resident.

Sources: Critical Incident System report (CIS) Licensee investigation documents, interview with DOC and other staff.

[#622]

WRITTEN NOTIFICATION REPORTING CERTAIN MATTERS TO DIRECTOR

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

1. Non-compliance with: LTCHA, 2007 s. 24 (1) 2.

The licensee has failed to immediately report an alleged incident of resident neglect to the Director.

Rationale and Summary

On a specified date a Personal Support Worker (PSW) reported to an RN that a resident had not received any care for 16 hours. The resident had been incontinent of urine and was distressed.
The RN reported the allegation of resident neglect to the Director of Care (DOC) by email the following morning however, had not reported the alleged incident of resident neglect to the Director immediately.

The incident of alleged resident neglect was reported to the Director one day after the incident took place.

Sources: Critical Incident System report (CIS), licensee investigation documents, interview with DOC and other staff.

[622]

2. Non-compliance with: LTCHA, 2007 s. 24 (1) 2.

The licensee has failed to immediately report an incident of resident to resident physical abuse to the Director.

Rationale and Summary

An incident of resident to resident physical abuse took place on a specified date and time. The incident was first reported to the Director via the after hours contact line the next morning at a specified time as verified by the Resident Services Supervisor. The licensee submitted a CI related to the physical abuse indicating that one of the residents involved suffered an injury as a result.

[733]

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

1. Non-compliance with: O. Reg. 246/22 s. 102 (2) b.

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control is implemented.
Specifically, the Minister's Directive: Covid-19 response measures for long-term care homes.
8. Licensees are required to ensure that the COVID-19 asymptomatic screen
testing requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, or as amended, are followed.

Rationale and Summary
The Covid – 19 Guidance Document for Long – Term Care Homes in Ontario states:
Where a staff member, student or volunteer takes an antigen test at the long-term care home the test must be taken as soon as possible after beginning a shift, and the individual may enter the home with appropriate PPE and following IPAC practices while waiting for the test results. Staff, student placements and volunteers should not provide direct care to residents until a negative test result is received.

Staff were providing direct care to residents for several hours before receiving a negative rapid antigen test.

The IPAC lead indicated that before they changed the hours for testing, staff were providing direct care to the residents from 0600 hours to 0900 hours before testing on their first break. The IPAC lead stated that just once to their knowledge, a staff member was tested after starting their shift, and was positive.

Sources: Minister's Directive: Covid-19 response measures for long-term care homes, COVID-19 Guidance Document for Long-Term Care Homes in Ontario, interviews with IPAC lead #107.

[740823]

2. Non-compliance with: O. Reg. 246/22 s 102 (2) (B)

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control program was implemented related to residents' hand hygiene.
In accordance with the Additional Requirement under 10.4 (h) of the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes dated April 2022, indicated that the licensee shall ensure to support residents to perform hand hygiene prior to receiving meals and snacks.

Rationale and Summary

On specified dates the lunch meal service observations on Stormont and Glengarry Units revealed that residents' hands were not cleaned before the meal.
An interview with a PSW indicated that residents' hands were not cleaned before meals. Lack of hand hygiene increases the risk of disease transmission among residents and staff.

Sources: Public Health Ontario - Best Practices for Hand Hygiene in All Health Care Settings, 4th Edition (April 2014), Inspector #733 observations of lunch service, and interview with a PSW
[733]

WRITTEN NOTIFICATION ADMINISTRATOR

NC#04 Written Notification pursuant to O. Reg 246/22 s.249. (1) 3.

The licensee has failed to ensure that an Administrator is in the home at least 35 hours per week.

The home has 132 beds and as per the legislation requires an administrator for 35 hours per week. Between July 25, 2022 and September 1, 2022 they did not meet the required 35 hours per week. The home had an acting Administrator for three days per week from July 15 to August 30 2022. The home hired a full-time administrator as of September 1, 2022.

COMPLIANCE ORDER C#001 INFECTION PREVENTION AND CONTROL PROGRAM

NC#05 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 102 (15) 2

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22 s. 102 (15) 2

The licensee shall

- Ensure that the designated IPAC lead works regularly in the position of IPAC lead for at least 26.25 hours per week.
- Keep a written record of the hours that the individual works in the home until the compliance order has been complied.

Grounds

Non-compliance with: O. Reg. 246/22 s. 102 (15) 2.

The licensee has failed to ensure that they have an IPAC Lead who works regularly in that position on site at the home for at least 26.25 hours per week.

The IPAC leads hours have not met the legislative requirement since July 30, 2022.

The individual currently working as the IPAC Lead spends 16 hours per week in that position.

This is a non-isolated concern that has an impact on all residents and potentially increases the risk of communicable diseases being spread more easily throughout the home.

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This order must be complied with by November 14, 2022

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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. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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:

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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
email: 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.