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
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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
Oct 30, 31, Nov 1, 5, 7, 9, 22, 2012	2012_200148_0004	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

AMANDA NIXON (148)

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, Director of Care, Nutritional Manager, Registered Nurses and Registered Practical Nurses and Personal Support Workers (PSW) responsible for resident care. The inspector also spoke with several residents.

During the course of the inspection, the inspector(s) reviewed the home's policy #MM-0704-08 titled "Resident Non Abuse", reviewed data related to the home's orientation of staff members, reviewed the health care records of several residents including plans of care and flow sheets. The inspector also observed resident care and the breakfast meal service on October 31, 2012.

This was an on-site inspection, October 30 and 31, 2012 related to two Critical Incident (CI) reports.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 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., in that a person who had reasonable rounds to suspect abuse of a resident did not immediately report it to the Director.

Critical Incident (CI) report submitted to the Ministry of Health and Long Term Care (MOHLTC) indicated that an alleged staff to resident abuse occurred, involving Resident #001. Resident #001 reported that Staff member #S103 was mean after requesting assistance with care.

Interview of DOC on October 30, 2012 confirmed the date of the alleged staff to resident abuse.

The CI report indicates that Staff member #S102, who first became aware of the alleged staff to resident abuse, reported the incident to the DOC (Acting) the day after the alleged abuse.

The Director was notified through the Critical Incident System (CIS) more than 24 hours after the alleged abuse occurred.

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 when there are reasonable grounds to suspect abuse of a resident that resulted in harm or risk of harm, that the suspicion and information shall be immediately reported to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following subsections:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s.76(4), in that three staff persons did not receive retraining on the home's abuse policy as per the intervals set out in O.Reg. 79/10 s.219(1).

O.Reg. 79/10 s.219(1) sets out annual intervals for retraining for the purposes of LTCHA 2007, S.O. 2007, c.8, s.76(4).

A review of documentation provided by the home demonstrates that Staff member #S103 was last retrained on the home's abuse policy in March 2012. The home could not provide evidence that the staff member had received training in 2011.

A review of the documentation provided by the home demonstrates that Staff member S#102 was retrained on the home's abuse policy in March 2010. The home could not provide evidence that the staff member had received retraining in 2011.

A review of the documentation provided by the home demonstrates that Staff member #S104 was provided training at orientation in 2010 and provided retraining June 2012. The home could not provide evidence that the staff member had received training in 2011.

The home was unable to provide evidence that staff persons #S102, #S103 and #S104 were provided with annual retraining of the home's policy #MM-0704-08 titled "Resident Non Abuse".

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 persons are provided with retraining of the home's abuse policy at intervals provide for in the regulations, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10 s.73(2)(a) in that no more than two residents, who require total assistance with eating or drinking shall be fed simultaneously by one person.

On October 31, 2012 Inspector #148 observed the breakfast meal on one unit. Resident #005, #006, and #007 were observed to be seated together at a table with Resident #008 and one PSW. The PSW was observed to provide feeding assistance to Resident #005, #006 and #007, simultaneously during the meal service.

The plans of care were reviewed for Resident #005, #006 and #007.
The plan of care for Resident #005 indicates that the resident is unable to feed self and requires feeding assistance.
The plan of care for Resident #006 indicates that the resident is unable to feed self and is provided with total feeding assistance.
The plan of care for Resident #007 indicates that the resident requires total feeding assistance.

Interview with the Nutritional Manager during the breakfast meal service on October 31, 2012, stated that Resident #005, #006 and 007, required total feeding assistance.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents
Specifically failed to comply with the following subsections:

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), in that the Substitute Decision Maker for Resident #001 was not notified within 12 hours of an alleged abuse of a resident.

A CI report submitted to the MOHLTC indicated that an alleged staff to resident abuse occurred, involving Resident #001. Resident #001 reported that Staff member #S103 was mean after requesting assistance with care.

The CI report indicates that Resident #001's Substitute Decision Maker was not notified due to the pending investigation.

A review of Resident #001's health care record demonstrates that there has been no notification to resident's Substitute Decision Maker, to date, of the alleged abuse. The Administrator of the home confirmed that as of November 1, 2012 the SDM of Resident #001 had not been informed of the alleged staff to resident abuse.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following subsections:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.23(1)(a)(i), in that an alleged incident of abuse of a resident was not immediately investigated.

CI report submitted to the MOHLTC indicates that an alleged staff to resident abuse occurred, involving Resident #001. Resident #001 reported that Staff member #S103 was mean after requesting assistance with care.
Interview of DOC on October 30, 2012 confirmed the date of the alleged staff to resident abuse.

CI report indicates that the Staff member #S102, who first became aware of the alleged staff to resident abuse, reported the incident to the DOC (Acting) the day after the alleged abuse occurred.

The DOC (Acting) began the home's investigation into the alleged staff to resident abuse one day after the alleged abuse incident.

Issued on this 22nd day of November, 2012

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

Amanda Nixon RD LTCH Inspector