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 sions de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 21, 2016	2016_195166_0007	005071-16	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF NORTHUMBERLAND
983 Burnham Street COBOURG ON K9A 5J6

Long-Term Care Home/Foyer de soins de longue durée

GOLDEN PLOUGH LODGE
983 BURNHAM STREET COBOURG ON K9A 5J6

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

CAROLINE TOMPKINS (166), DENISE BROWN (626), PATRICIA MATA (571), SARAH GILLIS (623)

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): March 7, 8, 9, 10, 11, 14 and 15, 2016

Complaint logs #036470-15 and #001544-16, related to alleged staff to resident abuse, log #004588-16 related to resident care and critical incident log #001544-16 related to an unexpected death were inspected concurrently with this Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, Resident Council representative, Family Council representatives, Resident Business Coordinator, Physicians, Administrator, Director of Care(DOC), Assistant Directors of Care(ADOC,) Life Enrichment Manager(LEM), member of the Behaviourial Support Team Ontario(BSO), Environmental Service Manager(ESM), Registered Nurses(RN), Registered Practical Nurses(RPN), Personal Support Workers(PSW), member of the housekeeping staff and member of the life enrichment staff.
During the course of the inspection the inspectors also toured residents' rooms including resident common areas, observed staff to resident interactions, observed a noon meal service, medication administration, infection control practices and scheduled social programs for residents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Trust Accounts

During the course of this inspection, Non-Compliances were issued.

2 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. Related to complaint log 036470-15

The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

A Critical Incident (CI) was received, reporting an incident of staff to resident abuse.

Review of the CI documentation indicated that staff #121 went to the nurses' station and demanded that resident #09 be removed from the dining room right away.
Personal Support Worker (PSW) #122, went to the dining room with staff #121.
PSW #122 observed staff #121 take the book the resident was reading from the resident's hand then grab the resident's chair and slide it back from the table.
Staff #121 then reached under the resident's arm and pulled aggressively to stand the resident up and move the resident out the room.
PSW #122 assisted the resident safely out the room. Staff #121 slammed the room door behind them.

A complaint was received from the Substitute Decision Maker(SDM) of resident #09 related to the same incident.

Review of the licensee's investigation notes indicates the DOC was made aware of the allegation of staff to resident abuse 9 days post incident

Interview with the DOC indicated that PSW #122 had commented on the incident to coworkers but did not report the incident to the charge nurse.

When PSW #122 returned to work and inquired about the results of the incident, it was then discovered the incident had not been reported.
When the DOC became aware of the allegation of abuse, the DOC immediately submitted the critical incident, notified the SDM and initiated the investigation.

The licensee's policy, related to the Prevention, Reporting and Elimination of Resident Abuse:

Staff and Volunteers of the Golden Plough Lodge who witness or suspect the abuse of a Resident or who receives complaints of abuse MUST report the matter without delay to their immediate supervisor and the Director of Care or designate, who then must immediately forward notification to the Administrator.

PSW #122, witnessed an incident of staff to resident abuse directed towards resident #09 by staff #121 but did not immediately report the incident to the supervisor and the Director of Care or designate as required by the licensee's prevention of abuse policy. [s. 20. (1)]

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 licensee's policy related to the reporting of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: 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. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. Related to complaint log 036470-15

The licensee has failed to ensure that the resident and resident's Substitute Decision Maker(SDM) were notified of the results of the abuse investigation immediately upon the completion.

When the licensee became aware of an alleged incident of staff to resident abuse, the investigation was initiated and resident #09's SDM was notified of the incident at that time.

Review of the licensee's investigation and interview with the two Assistant Directors of Care was not able to produce evidence that the resident's SDM was notified of the results immediately following the completion of the investigation.

Interview with resident #09's SDM indicated, the SDM had not been informed of the results of the licensee's investigation until the SDM made an inquiry about the results. [s. 97. (2)]

Issued on this 21st day of March, 2016

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

Original report signed by the inspector.