Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central West District
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Original Public Report

Report Issue Date: August 28, 2023	
Inspection Number: 2023-1026-0004	
Inspection Type: Complaint Critical Incident	
Licensee: Golden Years Nursing Homes (Cambridge) Inc.	
Long Term Care Home and City: Golden Years Nursing Home, Cambridge	
Lead Inspector Kaitlyn Puklicz (000685)	**Inspector Digital Signature** Kaitlyn Joan Puklicz Digitally signed by Kaitlyn Joan Puklicz Date: 2023.08.29 15:33:33 -04'00'
Additional Inspector(s) Maria McGill (728) was also present for this inspection	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 15-18, 2023

The following intake(s) were inspected:
- Intake: #00090827 - Allegations of staff to resident neglect
- Intake: #00092809 - Allegations of improper care of a resident

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

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

Introduction

The licensee has failed to ensure that a resident was reassessed, and their plan of care reviewed and revised when the resident's care needs changed.

Rationale and Summary

A resident displayed a change in their health condition which eventually led to hospitalization.

A complaint was received alleging that despite staff being aware of a resident's changing health condition, the resident did not receive appropriate care.

A Personal Support Worker (PSW) said they reported concerns about the resident's condition to a Registered Practical Nurse (RPN).

That RPN stated when PSWs approached them with concerns about the resident, they did not complete an assessment, nor make a referral to the physician despite noticing a change in the resident in the days leading up to their hospitalization.

No staff member had assessed for eight days prior to the resident's hospitalization despite repeated concerns of a change in the resident's health condition being expressed by care staff.

The Executive Director (ED) stated an assessment of the resident should have been completed.

Failing to reassess the resident and review and revise the resident's plan of care when their care needs changed, limited the home's ability to respond and intervene to the resident's changing condition.

Sources:
Clinical record review for the resident, interview with a PSW, RPN and ED.

[000685]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

Introduction

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was given the opportunity to participate fully in the implementation of the resident's plan of care.

Rationale and Summary

A resident displayed a change in their health condition, which eventually led to hospitalization.

A complaint was received stating that the SDM was not made aware of a resident's change in health condition.

There was no documentation during the two weeks prior to this resident's hospitalization indicating that staff had informed the resident's SDM of the change in their health condition.

An RPN stated the resident's SDM should have been contacted.

The ED stated it is an expectation that the resident's SDM be informed of changes in a resident's health condition.

Failing to communicate changes in the resident's health status to the resident's SDM limited their involvement in the plan of care and actions taken by the home, as well as knowledge of the resident's changing condition.

Sources:
Clinical record review for the resident, interview with an RPN and ED.

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WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (6) (b)

Introduction

The licensee has failed to ensure that a PSW was not discouraged from alleging neglect of a resident.

Rationale and Summary

A critical incident (CI) was submitted to the Director related to an allegation of neglect of a resident.

A PSW said they had reported an allegation of neglect. They said the management response eventually made them feel that they should change their story and indicate that the incident was not neglect.

Another staff member stated they felt management discouraged the PSW from reporting the incident as neglect.

The ED stated the PSW did allege neglect initially but later did not feel that the incident was neglect.

Persuading a staff member to change their report of an allegation of neglect may have a negative impact on the staff members reporting concerns to management of the home and subsequently to the Director.

Sources:

The home's investigative notes, interview with two staff members and the ED.

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