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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 8, 2014	2014_179103_0011	O-000188-14, O-000299-14	Complaint

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 6-8, 2014

During this inspection, two separate complaints were inspected.

During the course of the inspection, the inspector(s) spoke with a Registered Practical Nurse and the Director of Care.

During the course of the inspection, the inspector(s) reviewed the resident health care record and the home's Fall management policy.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 s. 6 (7) whereby care set out in the plan of care was not provided to the resident as specified in the plan.

Resident #1 was assessed as at risk for falls. The resident was known to attempt unsafe self transfers and had documented attempts to toilet self during the night. The resident plan of care with an identified date under "Falls" indicated the following as an intervention to prevent falls: resident to wear proper and non slip footwear.

During a review of the resident progress notes, it was noted that on an identified date on or about 0335hr, Resident #1 was found in bed wearing tight fitting socks. The socks were removed at that time as the resident complained of sore feet.

On another identified date approximately one month later, Resident #1 sustained a fall on or about 1830hr and at the time of the fall was found in sock feet. The resident had attempted to self transfer and reported he/she had slipped. [s. 6. (7)]

2. The licensee has failed to comply with LTCHA, 2007 s. 6 (11) (b) whereby different approaches were not considered when care set out in the resident plan of care were not effective.

Resident #1's health care record was reviewed and there was documented falls on five identified dates. The resident sustained a serious injury as a result of the last documented fall.

Following the first documented fall, there was evidence that the resident's toileting routine was adjusted to include night time toileting in an attempt to reduce the likelihood of unsafe self transfers.

On an identified date, the resident's family member requested a bed alarm be used so that staff would know when the resident was out of bed. Three days later, the staff discussed the pros and cons of a bed alarm for this resident and decided against the alarm because the volume was distressing to the resident and co-residents. The resident sustained four additional falls after that time and there was no evidence that additional alternatives were considered or implemented to reduce the resident risk for falls. A bed alarm was ordered two days after the resident sustained a serious injury. [s. 6. (11) (b)]

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 fall prevention interventions are provided to residents assessed to be at risk for falls as outlined in the plan of care and that different fall prevention approaches are considered when care set out in the resident plan of care are not effective, to be implemented voluntarily.

Issued on this 8th day of May, 2014

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