Ontario

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

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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 5, 2015	2015_236572_0005	O-001212-14, O-001329-14, O-001370-14, O-000188-13	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

BARBARA ROBINSON (572), WENDY BROWN (602)

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): February 11, 12 and 13, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Directors of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), a Dietician (RD), a physician, an Activity staff member, the Chaplain, Food Services staff, family members, and residents. The inspector(s) also toured the home, observed residents' care and services, reviewed resident health care records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Dignity, Choice and Privacy
Falls Prevention
Hospitalization and Change in Condition
Pain
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s.3, Residents' Bill of Rights.

Re: Log #O-001329-14:
A review of the healthcare record of Resident #2 indicates that the resident has multiple comorbidities.

1. The resident's right to be properly fed and cared for in a manner consistent with his or her needs was not fully respected and promoted (LTCHA 2007, s.3(1)4.)
A progress note for Resident #2 from a specified date states "As per DOC elder is to receive modified diet while in bed. Elder receives pureed diet therefore a modified diet would equal half portion meal."
In an interview on February 11, 2014, PSW #S111 stated that when Resident #2 refuses to get up for meals, he/she is provided a modified diet which means smaller portions. Resident #2 receives a pureed diet so PSW #S111 was concerned about maintaining nutrition.
In interviews on February 12 and 13, 2015, PSW #S110, PSW #S112, RPN #S114 and RPN #S116 confirmed that unless ill, when residents do not eat in the dining room they are provided with a modified meal which is smaller portions to encourage them to eat in the dining room.

In an interview on February 12, 2014 the Dietitian #S107 said that unless ill, residents receive a light meal in their room when they do not eat in the dining room. When asked about the meals for Resident #2 who has a specified health condition, the Dietitian said that the Resident would receive a full pureed meal. The DOC stated that if a resident

does not eat in the dining room they receive smaller portions as calculated by the Dietician.

2. The resident's right to participate in decision-making was not fully respected and promoted. (LTCHA 2007, s.3(1)9.)
On a specified date, Resident #2 told the Chaplain, #S106 that he/she felt his/her rights were not being respected as he/she was being forced to get out of bed for some meals against his/her wishes. The Resident was aware of the consequences of not getting up and since he/she was unable to get up independently, the Resident asked the Chaplain to contact the Ministry of Health on his/her behalf.

The two most recent consecutive Care Plans in place for Resident #2 both stated that Resident #2 "is to get out of bed for lunch and supper unless ill. If he/she refuses to get up, give him/her 5 minutes. Explain that you will be back to get him/her up. He/she is not to stay in bed for these meals."
In interviews on February 11, 2015, the Chaplain and PSW #S111 stated that the DOC said Resident #2 must get up from bed for lunch and supper to maintain health and adhere to Ministry standards. RPN #S108 also confirmed that Resident #2 was required to be up for lunch and supper. In an interview on February 12, 2014 the DOC stated she told staff that Resident #2 needed to be up for lunch and supper, "I just wanted them to try harder. I was quite firm about them making more attempts."

In interviews on February 11, 2014, PSW #S111 stated that after IL#35947-OT was submitted staff began to document the times when Resident #2 refused to get up and provide tray service in his/her room. RN #S100 and RPN#S101confirmed that Resident #2 now eats some meals in his/her room. Resident #2 could not recall the Ministry complaint but stated that a long time ago he/she could not have meals in bed, but now he/she can do so and was pleased about this. [s. 3. (1) 4.]

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 every resident has his or her right to be properly fed and cared for in a manner consistent with his or her needs respected, as well as his or her right to participate in decisions respected, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 42 whereby the licensee did not ensure that every resident receives end-of-life care when required in a manner that meets their needs.

Re: Log O-001212-14:
A review of the healthcare record of Resident #1 and IL #35506-OT indicates that Resident #1 had multiple comorbidities. The Resident routinely received regular doses of analgesics daily and doses as needed (PRN) for ongoing pain. Resident #1 also received an anti-emetic once daily.

On a specified date, Resident #1 was found after a fall, in severe pain. The Resident's POA made a decision with the doctor to treat with palliative care in the home. No changes were made to the resident's medication profile at that time.

A progress note from a specified date stated that Resident #1 had a restless night after the fall with nausea and that the Resident was screaming in pain when moved. Throughout the night Resident #1 received four doses of PRN analgesics. All four doses were assessed as being ineffective but no action was taken to contact the physician to reassess for changes in medication.
Resident #1 had a short unresponsive period the next day, so was returned to bed. The

progress notes document the status of Resident #1 as being diaphoretic, pale and agitated with complaints of significant, unremitting pain. The dose of the Resident's oral analgesic was increased but he/she continued to vomit; the analgesics continued to be documented as ineffective.

The physician was contacted because of ongoing distress experienced by Resident #1 from unrelieved pain and vomiting. Orders were obtained later in the day for parenteral analgesic and anti-emetic medications. Resident #1 received these medications which enabled Resident #1 to finally rest comfortably. Further injectible medications were provided as ordered until he/she passed away that night.

In an interview on February 11, 2015, the daughter of Resident #1 described the Resident's final hours of life after his/her fall as hours of pain and suffering.

In an interview on February 13, 2015, both RN #S117 and RPN #S118 acknowledged that the day was very busy but Resident #1 should not have experienced over 16 hours of suffering from the time of his/her fall until the Resident was finally provided with effective parenteral medication to mitigate symptoms of severe pain and nausea/vomiting. The DOC and Administrator also confirmed that Resident #1 should not have waited over 16 hours to be provided with adequate medication to relieve significant pain and vomiting as per the palliative care process. [s. 42.]

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 every resident receives end-of-life-care when required in a manner that meets their needs, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (6) The licensee shall ensure that the care set out in the care plan is provided to the resident as specified in the plan. O. Reg. 79/10, s. 24 (6).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 24(6) whereby the licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A review of the clinical health record for Resident #3 identified a physician's order from a specified date that increased the resident's antihypertensive medication with associated Blood Pressure (BP) monitoring twice daily x7 days. BP record indicates twice daily monitoring was not done on 3 of the 5 subsequent days, with transfer to hospital required 5 days later. [s. 24. (6)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The Licensee has failed to comply with LTCHA 2007, s. 44(9)(b) whereby the licensee did not ensure that the written notice withholding approval for admission given to the applicant included a detailed explanation of the supporting facts as they relate both to the Home and to the applicant's condition and requirements for care.

A review of a written notice on a specified date sent to the applicant indicated approval would be withheld stating that the Home did "not have the necessary resources" to meet the applicant's "needs". The explanation provided was as follows:

"Your infection control requirements are such that the Home cannot accommodate your care needs and ensure safety of other residents in a basic shared accommodation".

The Home's Director of Care (DOC) was interviewed. She advised Inspector #602 that she is responsible for reviewing applications submitted to the Home by the Community Care Access Centre (CCAC) and had assessed this applicant's admissibility. The DOC clarified the reasons supporting withholding approval as follows:
- would require "sharing a room"
- several co-morbidities
- CCAC notes indicated applicant "disregarding infection control" precautions
- Refusal of "some medications" and certain "treatments".

However, none of the above reasons were included in the written notice withholding approval.

The Senior Manager for Placement Coordination Services at the Central East CCAC was interviewed by telephone. She explained the value of including detailed explanations with supporting facts in written notices as this information alerts the applicant and care providers (CCAC, Hospital) to the issues that need to be addressed prior to future applications for admission to Long-Term Care.

The Home is not in compliance with the LTCHA, 2007 s. 44 (9) (b) as a detailed explanation of supporting facts, as they relate both to the Home and to the infection control requirements of the applicant were not provided in the written notice. Further, there was no explanation of how the supporting facts justify the decision to withhold approval as set out in LTCHA, 2007 s. 44 (9) (c). [s. 44. (9) (b)]

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Issued on this 16th day of March, 2015

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

Original report signed by the inspector.