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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 14, 2015	2015_396103_0046	O-002369-15	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

DARLENE MURPHY (103), AMBER MOASE (541), JESSICA PATTISON (197), PATRICIA MATA (571), SAMI JAROUR (570)

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): August 4-7, 10-12, 2015

The following intakes were included in this inspection: O-001883-15, O-001906-15, and O-002211-15.

During the course of the inspection, the inspector(s) spoke with Residents, Representative of Resident Council, Representative of Family Council, Family members, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Environmental Manager, Housekeeping staff, Scheduling Clerk, RAI Coordinator, Physiotherapist, Assistant Director of Care, Acting Director of Care and the Administrator.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

10 WN(s)
3 VPC(s)
1 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 O.Reg 79/10, s. 31. Nursing and personal support services

Findings/Faits saillants :

1. Re: Log #-O-001906-15

The licensee has failed to comply with O. Reg 79/10, s. 31 (1) whereby the home failed to ensure there was an organized program of personal support services as required under clause 8 (1) (b) of the Act to meet the assessed needs of the residents.

On an identified date, the home was short-staffed. Resident #42 experienced a medical emergency, was sent to hospital and passed away on an identified date nine days later.

Resident #42's physician orders listed specifics related to positioning and location during meals and the resident plan of care included specifics related to the resident's required supervision during meals.

PSW #S117 stated as a result of being short staffed, they were not able to get many residents out of bed, including resident #42 who received lunch in bed.

During an interview, PSW #S112 stated she provided Resident #42 with a lunch tray and observed them beginning to eat. PSW #S112 stated she then left the resident to document just outside the resident's room where she could still see some of the resident's bed. PSW#S112 re entered the resident room a short time later where she found the resident was having a medical emergency.

According to interviews with PSW#117 and RPN#118, there are normally 3 full shift PSW's and 1 four hour PSW working between the identified units on the 7am-3pm shift.

During an interview with PSW #S117, it was confirmed that on the identified date from 7am-3pm on the identified units this PSW and one other more newly hired PSW were the only PSW staff working to cover the entire unit. PSW #S117 stated it was a difficult shift. She stated residents were ringing to get out of bed and she recalled one family member was angry that staff could not assist their family member in a timely manner.

PSW#S117 indicated no personal care was provided to residents who required assistance between 7-11 am on the identified date. Inspector #197 interviewed PSW#S112 who worked on the identified unit from 11am-11 pm on the identified date. PSW #S112 stated that when she arrived for her shift at 11am, many residents were still in bed and no scheduled baths were completed during her 12 hour shift.

Point of Care (POC) Documentation Compliance Report from the identified date indicated there were 332 scheduled tasks to complete during the day shift. Only 21 (6.33%) tasks were completed that shift. Inspector #572 interviewed the Acting DOC who stated it was unusual for only this number of tasks to be completed on a shift.

The home failed to ensure there was an organized program for personal support services to meet the assessed needs of residents on the identified date.

Due to the negative outcome for Resident #42 and the lack of personal support services provided to other residents on the unit, a compliance order is indicated. [s. 31.]

2. The licensee has failed to comply with O. Reg 79/10 s. 31 (2) whereby there is no written staffing plan for the nursing and personal support services programs.

This inspector spoke with the Administrator, Acting DOC, the Assistant DOC and the scheduling clerk and requested a copy of the home's staffing plan. Both the ADOC and the scheduler did state the home has a call in procedure and provided it to this inspector to review. The call in procedure did outline how to replace staff when they are absent from their assigned shifts but did not constitute the details that are legislated to be included in a staffing plan.

None of the interviewed staff were able to describe any back up plans or changes to shift routines that would be put into place when staffing is less than optimal. [s. 31.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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).

Findings/Faits saillants :

Re: Log #O-001883-15

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

On an identified date, Resident #42 received their meal via tray service to their room while in bed. PSW #S112 stayed with the Resident while they had the first bite and then left the room to complete charting in the hallway just outside the Resident's room. PSW #S112 states she was gone from the room for two minutes, re-entered the Resident's room and saw the resident was having a medical emergency. PSW #S112 immediately called Registered staff for help.

Resident #42's care plan dated on an identified date states the following:
- Requires assistance to prevent decline of function from maximum self-sufficiency for eating related to: mobility issues.
- Assist resident with eating when resident becomes fatigued
- Resident is to get up for each meal. To eat under supervision for all meals; ensure RPN is informed if resident is refusing to eat
- Ensure dentures are in place before each meal
- Provide constant encouragement remaining with resident during meals

There is also a Physician's Order on Resident #42's Medication Administration Record that gives specific identified instructions related to resident positioning and location during meals.

A Medication Administration Note dated on an identified date, indicated "Resident remained in bed". The RPN who charted this was not available for interview during the inspection period.

On August 10, 2015 during an interview, PSW #S112 stated that she arrived on the resident unit at 1100 hours after being called in to work to cover a shift. She states that

they were short-staffed on this day and when she arrived all residents that required the lift to get out of bed were still in bed, including Resident #42. PSW #S112 indicated that she had not worked on this unit in awhile. Her understanding was that Resident #42 could remain in bed to eat while staff were close by.

On August 11, 2015, PSW #S113 was interviewed since she had also worked on the identified resident unit on that identified date. She stated that she did not witness the incident. She said that she thinks they were short-staffed that day and that it was an extremely hectic shift. She said they planned to get Resident #42 out of bed after breakfast but never did.

On August 10, 2015, RN #S114 was interviewed and stated that she was called STAT to Resident #42's room on the identified date just after lunch. She responded immediately, assessing the Resident and requesting other staff to call 911 and bring an identified piece of equipment. The RN stated that it is protocol for staff to remain in the room if a resident is eating in their room and this applies to any resident.

Progress notes indicate that Resident #42 went to hospital, was assessed and family decided that they wanted comfort measures only. Resident #42 was transferred back to the home and passed away on an identified date. [s. 6. (7)]

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 all residents with this identified nutritional risk are provided care as specified in their plan of care, 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:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 73(1)8 whereby a lunch meal was not served course by course.

On August 10, 2015, lunch observation was completed on an identified resident area.

The lunch meal began at 1230 hours and at 1236 hours Residents #6 and #43 were eating their soup. Resident #6 was receiving total feeding assistance from a staff member, while Resident #43 was feeding themself. At 1240 hours, both residents were provided with their entree while they were still eating their soup. At 1244 hours, Resident #6 finished the soup and staff began to feed the resident the entree. At 1247 hours, Resident #43 finished their soup and began eating the entree.

Resident #43 and #6 were not served their lunch meal course by course. Care plans were reviewed for both residents and there was nothing to indicate that their assessed needs or preferences were not to be served course by course. [s. 73. (1) 8.]

2. The licensee has failed to comply with O. Reg. 79/10, s. 73(1)10 in that proper techniques and safe positioning was not used to assist resident's with eating who require assistance.

On August 4, 2015, lunch observation was completed on an identified resident area beginning at 1200 hours.

At approximately 1210 hours, RPN #S103 was observed to feed a resident soup while

standing.

At approximately 1225 hours, a PSW was observed to feed Resident #23 a drink and their meal while standing.

Resident #23 was observed in a reclined position with their head tilted back while being fed by staff. Resident #23's care plan dated June 28, 2015 states that the Resident is at high nutritional risk related to uncontrolled diabetes and difficulty chewing and swallowing regular texture foods. The care plan also indicates that the Resident requires total to extensive feeding assistance at times.

Resident #45 was observed to be eating the lunch meal while reclined to about a forty-five degree angle in a Broda chair. The Resident appeared to be struggling to eat at this angle so the inspector asked Resident #45 if they were comfortable to eat in this position. The Resident replied that they felt they could be a bit more upright. The care plan for Resident #45 dated August 3, 2015 states that the resident requires assistance due to cognitive deficit and they are a moderate nutritional risk related to leaving 25% of meals uneaten at some meals and has difficulty chewing regular texture foods.

An interview was conducted with the Physiotherapist on August 11, 2015 related to the positioning of residents during meals. He stated that both Residents #23 and #45 are to be in an upright position during meals and should not be reclined.

On August 7, 2015 in the McMillan Cottage resident area, a PSW was observed to feed Resident #44 part of the lunch meal while standing. [s. 73. (1) 10.]

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 all residents receive course by course service of meals unless otherwise indicated by the assessed needs of the resident or requested by the resident and that all residents are safely positioned during meals, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (4) The licensee shall ensure that the emergency plans provide for the following:
3. Resources, supplies and equipment vital for the emergency response being set aside and readily available at the home. O. Reg. 79/10, s. 230 (4).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 230(4)3 in that the emergency plans for the home did not provide for supplies and equipment vital for the emergency response being set aside and readily available in the home.

On an identified date, Resident #42 experienced a medical emergency and needed emergency medical intervention. RN #S114 was called STAT to assess the Resident, at which time she requested that another staff member get an identified piece of equipment.

The home's protocol related to this medical equipment dated December 2014 states that "Registered Staff are to ensure that at all times the identified piece of equipment is clean, equipped and ready of use".

Interviews were conducted with PSW's #S112 and #S113, as well as RN #S114 related to the incident. PSW's #S112 and #S113 stated that it took some time to find the identified piece of equipment as they did not know where it was kept. PSW #S113 stated that before this incident staff had not been educated on where this identified piece of equipment was located throughout the home. Both PSW's then stated that once the identified piece of equipment was found, it was missing a piece.

RN #S114 stated that she was unaware of where the identified piece of equipment was kept since at the time she was a casual RN.

A progress note entered on an identified date written by RPN #S119 who responded to the incident stated the equipment arrived and was not ready for use.

During an interview with the acting Director of Care (DOC) on August 10, 2015, she indicated that she was aware a piece of the identified equipment was missing on that identified date and that staff had difficulty locating the equipment. She stated that at the time of the incident there was no process in place to ensure that all of the identified equipment was ready for use and to ensure that staff knew where to locate them. Since this time a monitoring system is now in place and staff have been informed where the identified equipment is kept. [s. 230. (4) 3.]

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 all supplies and equipment vital for emergency response to the identified emergency is readily available, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure all doors leading to non-residential areas were kept closed and locked when not being supervised by staff.

On August 4 and 5, 2015, Inspectors observed a room on MacMillian Cottage labelled "Storage/Hot water" with the door closed but unlocked. This room contained a hot water tank, a weigh scale and a refrigerator which contained trays of desserts prepared for resident meals and a variety of additional food items. At the time of these observations there were no staff noted to be in the vicinity.

On August 10, 2015, this same room was observed to have the door propped open, there were no staff observed in the area and several residents were observed in an adjacent area watching television. This inspector noted a jagged ceiling light fixture was located in the corner of the room and a piece of wood with two large nails protruding through the wood was observed sitting on top of the hot water tank. The Acting Director of Care was asked to come and view the room. She agreed the room would not be considered a resident area, secured the room and issued a memo to all staff in regards to the need to secure this door. [s. 9. (1) 2.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 14. Every licensee of a long-term care home shall ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall. O. Reg. 79/10, s. 14.

Findings/Faits saillants :

1. The licensee has failed to ensure every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall.

On August 4, 2015, Tub room #4 located on the Macmillan Cottage was observed to have one L-shaped grab bar located on the same wall as the faucet. On the same wall, a second straight rail was noted to be located to the left of the L-shaped grab bar. There was no grab bar located on the adjacent wall. PSW S#117 stated this tub room is primarily used for showering residents. [s. 14.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

2. A description of the individuals involved in the incident, including,

i. names of any residents involved in the incident,

ii. names of any staff members or other persons who were present at or discovered the incident, and

iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. Re: Log 002211-15:

The licensee has failed to ensure the Director was immediately informed of an outbreak of a reportable disease.

On an identified date, the local Public Health unit declared a respiratory outbreak in the home. The Director (MOHLTC) was informed of the outbreak for the first time by means of a critical incident report which was submitted by the home six days later. [s. 107. (1)]

2. Re: log 001883-15:

The licensee has failed to ensure the names of any staff members or other persons who were present at or discovered the incident were included in the written report submitted to the Director.

The home submitted a critical incident report on an identified date. The home failed to include PSW S#112 as a staff member who was present during the identified incident. [s. 107. (4) 2.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all drugs are stored in an area that is used exclusively for drugs and drug-related supplies and that is secure and locked.

On August 3-7, 2015, several vials of prescription medicated creams and scalp lotions were observed on several PSW care carts on McMillan Cottage. The medicated creams and lotions were on a shelf on one cart and located in an unlocked plastic bin on two other carts.

In an interview, RN S#104 indicated that all treatment creams and lotions are to be locked up before and after administration. [s. 129. (1) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #23's blood sugar was checked before lunch for determination of amount of insulin to administer by sliding scale.

On August 4, 2015, RPN S#103 was observed checking Resident #23's blood sugar and administering insulin after the Resident had completed their meal.

A review of the clinical record indicates that the physician prescribed Resident #23 to have a blood sugar test three times daily. The electronic medication administration record refers the Nurse to see the sliding scale for insulin based on pre-meal blood glucose. On August 4, additional units of insulin were administered after lunch based on a sliding scale for a post-meal blood sugar.

In an interview, the Acting Director of Care, indicated that it was the expectation that staff check a resident's blood sugar before a meal. [s. 131. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee has failed to ensure the record of quality improvement and utilization review system maintained by the home included the persons who participated in the evaluations and the dates improvements were implemented.

This inspector had a discussion with the Administration in regards to the completed Quality Improvement Checklist whereby she indicated "No" for question #5 which states does the licensee maintain a record of the names of the persons who participated in evaluations, and the dates improvements were implemented? The Administrator stated she was unsure if this was being done and directed this inspector to speak with the ADOC.

Following a discussion with the ADOC, it was determined the home is currently not consistently including the names of persons who participated in the evaluations and the dates improvements were implemented. [s. 228. 4.]

Issued on this 14th day of August, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARLENE MURPHY (103), AMBER MOASE (541), JESSICA PATTISON (197), PATRICIA MATA (571), SAMI JAROUR (570)
Inspection No. / No de l'inspection :	2015_396103_0046
Log No. / Registre no:	O-002369-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 14, 2015
Licensee / Titulaire de permis :	THE CORPORATION OF THE COUNTY OF NORTHUMBERLAND 983 Burnham Street, COBOURG, ON, K9A-5J6
LTC Home / Foyer de SLD :	GOLDEN PLOUGH LODGE 983 BURNHAM STREET, COBOURG, ON, K9A-5J6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Clare Dawson

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

To THE CORPORATION OF THE COUNTY OF NORTHUMBERLAND, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. Nursing and personal support services

Order / Ordre :

The licensee is hereby ordered to develop a staffing plan that includes the following:

-provides for a staffing mix that is consistent with resident's assessed care and safety needs and that meets the requirements set out in the Act and Regulation,
-sets out the organization and scheduling of staff shifts,
-promotes continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident,
-includes a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work, and
-be evaluated and updated at least annually.

Grounds / Motifs :

1. Re: Log #-O-001906-15

The licensee has failed to comply with O. Reg 79/10, s. 31 (1) whereby the home failed to ensure there was an organized program of personal support services as required under clause 8 (1) (b) of the Act to meet the assessed needs of the residents.

On an identified date, the home was short-staffed. Resident #42 experienced a medical emergency, was sent to hospital and passed away on an identified date nine days later.

Resident #42's physician orders listed specifics related to positioning and location during meals and the resident plan of care included specifics related to the resident's required supervision during meals.

PSW #S117 stated as a result of being short staffed, they were not able to get many residents out of bed, including resident #42 who received lunch in bed.

During an interview, PSW #S112 stated she provided Resident #42 with a lunch tray and observed them beginning to eat. PSW #S112 stated she then left the resident to document just outside the resident's room where she could still see some of the resident's bed. PSW#S112 re entered the resident room a short time later where she found the resident was having a medical emergency.

According to interviews with PSW#117 and RPN#118, there are normally 3 full shift PSW's and 1 four hour PSW working between the identified units on the 7am-3pm shift.

During an interview with PSW #S117, it was confirmed that on the identified date from 7am-3pm on the identified units this PSW and one other more newly hired PSW were the only PSW staff working to cover the entire unit. PSW #S117 stated it was a difficult shift. She stated residents were ringing to get out of bed and she recalled one family member was angry that staff could not assist their family member in a timely manner.

PSW#S117 indicated no personal care was provided to residents who required assistance between 7-11 am on the identified date. Inspector #197 interviewed PSW#S112 who worked on the identified unit from 11am-11 pm on the identified date. PSW #S112 stated that when she arrived for her shift at 11am, many residents were still in bed and no scheduled baths were completed during her 12 hour shift.

Point of Care (POC) Documentation Compliance Report from the identified date indicated there were 332 scheduled tasks to complete during the day shift. Only 21 (6.33%) tasks were completed that shift. Inspector #572 interviewed the Acting DOC who stated it was unusual for only this number of tasks to be completed on a shift.

The home failed to ensure there was an organized program for personal support services to meet the assessed needs of residents on the identified date.

Due to the negative outcome for Resident #42 and the lack of personal support services provided to other residents on the unit, a compliance order is indicated.

[s. 31.]

(541)

2. The licensee has failed to comply with O. Reg 79/10 s. 31 (2) whereby there is no written staffing plan for the nursing and personal support services programs.

This inspector spoke with the Administrator, Acting DOC, the Assistant DOC and the scheduling clerk and requested a copy of the home's staffing plan. Both the ADOC and the scheduler did state the home has a call in procedure and provided it to this inspector to review. The call in procedure did outline how to replace staff when they are absent from their assigned shifts but did not constitute the details that are legislated to be included in a staffing plan.

None of the interviewed staff were able to describe any back up plans or changes to shift routines that would be put into place when staffing is less than optimal. [s. 31.]

(103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 28, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 14th day of August, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DARLENE MURPHY

Service Area Office /
Bureau régional de services : Ottawa Service Area Office