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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection 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
Jul 28, 2016	2016_397607_0017	018037-16	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

JULIET MANDERSON-GRAY (607)

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): July 13, 14, 15, 2016.

During this Complaint Inspection, the following intake was reviewed and inspected upon #018037-16.

Summary of the Intake:

1) #018037-16- Complaint, regarding plan of care

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director Care (ADOC), a Registered Nurse (RN), Personal Support Workers (PSW), and a Substitute Decision Maker (SDM).

During the course of the inspection the inspector reviewed clinical health records, observed staff to resident interactions, reviewed home specific policies related to skin and wound, and reporting of complaints

The following Inspection Protocols were used during this inspection:
Personal Support Services
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Resident #004 has diagnosis related to a body part and has an order in place to apply a treatment to this body part at a specific time period.

A review of the Medication Administration Record (MAR) for the an identified month, for resident #004 directs the registered staff to apply this treatment at an identified time, and this was being signed for as being applied. Included in the MAR of an identified month was Registered Practical Nurses are to check that the treatment is applied at an identified time after its application; and at another identified time, this was also being signed by the registered staff as being completed on a daily basis.

A review of the electronic care plan indicated that Personal Support Workers (PSW) and RPN's are to check resident #004's body part to ensure that this treatment is applied at an identified time.

An interview with PSW #108 and RN #109 indicated that resident #004's treatment was being applied by the PSW's and registered staff do not apply the treatment.

Interview with RN #109 and ADOC #107 confirmed that the plan of care does not provide clear directions to staff.

Therefore the licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #004. [s. 6. (1) (c)]

2. The license has failed to ensure that the resident was reassessed when the care set out in the plan has not been effective.

A review of the plan of care dated revised on an identified date, indicated the following documentation related to resident #004.

"has a special treatment in place and staff are to alternate; staff to use special rubber gloves provided to apply and remove treatment; may wear disposable gloves inside rubber gloves. If staffs are unsure of proper application, please refer to full time (F/T) staff, RPN or family member for direction. There are pictures in the medication room of correct and incorrect treatment application. PSW and RPN are to check with resident #004 throughout the shift to see if treatment applied and the resident is comfortable at an identified time"

During an identified time period, resident #004 family member indicated several complaints were brought forward to the home including the CEO regarding resident #004's treatment and the appropriateness of its application noted when in to visit. The family member showed the inspector several pictures that was taken of resident #004's treatment indicating that it was not applied appropriately and further indicated these pictures were brought forward to the home. Upon observation of the pictures by the inspector, there were noted red marks to the resident's body part from the treatment not being applied appropriately. The DOC indicated that he/she was aware of the pictures and the concerns brought forward by resident #004's family member related to the treatment and staff not applying this appropriately, but did not follow-up with the family member as he/she might have been on vacation.

A review of an assessment completed by an identified specialist directs that it is important that resident #004's treatment be applied appropriately, as inappropriate application could cause harm to the resident's body part. A review of the clinical records revealed that the last assessment of resident #004's body part related to the treatment being applied was completed on an identified date, and an order was put in place by the Medical Director on an identified date.

Interview with PSW #108 indicated that the treatment being applied to the resident was not suitable and also felt that the resident needed to be reassessed, as this was being applied with no difficulties.

In spite of the above mentioned complaint brought forward by resident #004's family member, the resident was not assessed, the resident's plan of care was not revised until an identified date, and no new approaches were considered until an identified date when the DOC sent an email to a vendor to have the resident reassessed.

Therefore, the license has failed to ensure that the resident was reassessed when the care set out in the plan has not been effective, specifically related to resident #004. [s. 6. (10) (c)]

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 plan of care set out clear directions to staff and others who provide direct care to the resident #004, and ensure that the resident is reassessed when the care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident, a response has been made to the person who made the complaint, indicating:
i. what the licensee has done to resolve the complaint.

Resident #004's family member indicated that he/she had spoken with the DOC on an identified date, regarding the application of the resident's treatment and its inappropriate application noted when in to visit.

During an interview on an identified date the DOC indicated that he/she was aware of this complaint and there was an investigation. This complaint was treated as verbal complaint.

Interview with the resident's family member indicated that he/she had not heard from the

DOC of care since the complaint was made on an identified date and therefore contacted the CEO an identified date. The family member further mentioned that he/she then went back to the DOC of Care on an identified date and showed him/her pictures of resident #004's treatment not being applied appropriately; and at that time, the DOC mentioned that he/she was going to try and do something about the concern brought forward. The family member further indicated that he/she did not hear from the DOC in relation to what was going to be done regarding resident #004's treatment. The family member further indicated that he/she then went back to the DOC on an identified date, and at that time was told that someone was going to come in to reassess resident #004's body part for new treatment.

Interview with the DOC revealed that he/she might have been on vacation and did not get back to resident #004's family member.

Therefore the licensee has failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident, a response has been made to the person who made the complaint, indicating what the licensee has done to resolve the complaint specifically related to resident #004. [s. 101. (1) 3.]

2. The licensee has failed to ensure that a documented record is kept in the home that includes
a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant

Resident #004's family member indicated that he/she had spoken with DOC on an identified date, regarding the application of resident #004's treatment and its inappropriate application noted when in to visit.

During an interview on an identified date the DOC indicated that he/she was aware of this complaint and there was an investigation and the complaint was treated as verbal a complaint.

A review of the home's complaint logs for an identified time period could not locate documentation of the above mentioned complaint brought forward by resident #004's family member.

Interview with the DOC revealed that the complaint was not logged as he/she did not feel it was a new concern, as the resident family member had brought forward the same concern previously related to resident #004's treatment.

Therefore licensee has failed to ensure that a documented record is kept in the home specifically related to resident #004. [s. 101. (2)]

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 for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident, a response has been made to the person who made the complaint, indicating what the licensee has done to resolve the complaint, and will ensure that documented record is kept in the home that includes
a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant, specifically related to resident #004, to be implemented voluntarily.

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Issued on this 28th day of July, 2016

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

Original report signed by the inspector.