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

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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
Apr 20, 2017	2017_603194_0010	002756-17	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

CHANTAL LAFRENIERE (194), CATHI KERR (641), JENNIFER BATTEN (672), JULIET MANDERSON-GRAY (607), 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): March 6, 7, 8, 9, 10, 13, 14, 15, 16,17, 18 and 20, 2017

The following Logs have been completed during the inspection; Complaint Log #021064 related to provision of resident care, Critical Incident Logs #028872-16, #031116-16, #034722-16 related to allegations of resident to resident physical abuse, #030242-16 related to allegations of staff to resident verbal abuse, #002097-17 related to allegations of staff to resident neglect, #004530-17 related to allegations of resident to resident sexual abuse and Log #034998-16 follow up inspection for outstanding order under s. 19.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Assistant Director of Cares (ADOC), Registered Physio Therapist (PT), Physio Therapist Assistants (PTA), Maintenance Manager, Environmental support staff, Environmental Services Manager (ESM), Life Enrichment Aide (LEA), Behavioural Support Ontario (BSO), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Presidents of Resident and Family Councils, Residents and Families.

The inspectors also conducted a tour of the home. Observed infection control practices, Medication administration, service in the Dining area and provision of staff to resident care. Reviewed relevant policies, identified clinical health records, internal abuse investigation and staff educational records,

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_397607_0016	194

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. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction is
a) Documented, together with a record of the immediate actions taken to assess and maintain the resident's health
b) Reported to the resident, the resident's substitute decision maker, Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician and the pharmacy service provider

Review of the medication incident reports for a three month period were completed by inspectors #194 and #672. A total of eighteen medication incidents were reported in this period. Eleven of the eighteen medication incidents involved high risk medications. The following medication incidents also identified residents that did not receive medications as prescribed. (see WN #3). The high risk medications are dispensed by the pharmacy provider with Individual Narcotic Count Cards for a seven day period. Medication errors were noted to be identified at the end of the seven day period when medications were not signed for by the Registered staff and remained in the medication cart. The

medication errors reviewed did not have assessments completed for the identified residents, as the medication errors were not identified for a number of days after the medication incidents occurred.(See WN #1)

Review of resident #053 medication review report for an identified date indicated that resident #053 was prescribed an analgesic by mouth once per day.

Review of resident #053's Medication Administration Record (MAR) indicated that on an identified date RPN #114 signed the MARs as having administered the medication.

A medication incident report was submitted for a medication error occurring on the previous day. The incident report indicated that RPN #114 self reported administering the incorrect dose of the medication to resident #053.

During interview with inspector #672 on March 20, 2017 . RPN #114 explained that resident #053 had a routine dose of medication prescribed, three times a day as well as a different dosage of the same medication at noon, and an as needed dosage of the medication (PRN) in the medication cart. RPN #114 indicated selecting the wrong medication card in the medication cart and administered the incorrect dosage of the medication resident #053. RPN #114 indicated to inspector #672 during the same interview that resident #053 did not have a specific assessment completed related to the medication error, indicating that resident #053 was receiving this medication ongoing and the RPN did not notice any changes related to the resident's condition during the identified period.

Review of resident #028's Medication Review Report, on an identified date indicated that resident #028 was ordered an analgesic. The order provided specific guidelines on how to apply the medication.

Review of resident #028's Medication Administration Record (MAR) indicated that on an identified date RPN #146 signed the MAR as having applied the analgesic.

A medication incident report was completed on an identified date, for a medication incident which occurred three days previously. The incident report indicated that on an identified date, RPN #148 noted when administering the analgesic to resident #028, that the analgesic that had been applied previously by RPN #146 was not applied as directed resulting in an incorrect dosage of analgesic being administered. Review of the clinical health record for resident #028 was completed by inspector #194 with no evidence of an

assessment related to the medication error documented. The clinical health record did not indicate any changes in resident #028's pain during the identified period.

On the back of the Medication Incident/Near Incident Report, RPN #146 documented that the incident occurred due to "Unfamiliar with the unit and the shift. Didn't read the order properly".

Review of resident #031's Medication Review Report, on an identified date indicated that resident #031 was ordered a medication by mouth once per day.

Review of resident #031's Medication Administration Record (MAR), indicated that on an identified date, RPN #102 had signed the MAR as having administered the medication.

A medication incident report was completed by RPN #114, for a medication incident which had occurred on two days previously. The incident report indicated that, RPN #102 had signed the Medication Administration Record (MAR) as having administered the medication, but the medication had not been administered to the resident.

RPN #114 indicated during interview with Inspector #672 that a medication error was noted during the medication pass. RPN #114 noted that the Resident Count Card was off, further review through the MAR and the Resident Count Card sheet, indicated that the medication error occurred two days previously. RPN#102 had signed the MAR's as having given the medication, but there was an extra tab of the medication left in the card, and the administration had not been signed off as given on the Resident Count Card sheet. RPN #114 stated there was no need to complete a resident assessment, as resident #031 was quite independent, and would report to the staff if the resident was feeling that there was anything wrong. RPN #114 also stated that due to the incident being two days prior, that an assessment would not have necessarily benefited the resident.

Review of the clinical health records for residents #028, #031, #053 were completed by inspector #672 and #194 with no evidence of POAs or residents informed of the medication errors. The Clinical health records reviewed did not have evidence to support that any assessment of the residents had been completed related to the medication errors.

The SDM for resident #021 indicated that he/she was going over the resident #021's Medication Administration Records (MAR) and notice that a medication was not signed

as being administered.

A review of the MARs for resident #021 for a period of three months was completed and indicated that there were eight incidents where resident #021's medication was not signed as being administered.

Interview with RPN #102, indicated that the medications were administered to resident #021 but were not signed for.

During interview RPN #101 indicated having missed administering the scheduled medications.

In an interview ADOC #107 indicated that she had not received any medication incident reports involving resident #021 for the above identified months, and the home's expectation is that the registered staff self-report when there is a medication error as well as report this to the RN in charge of the unit.(607) [s. 135. (1)]

2. The licensee has failed to ensure that all medication incidents and adverse drug reactions are documented, reviewed and analyzed
(b) corrective action is taken as necessary, and
(c) a written record is kept of everything required under clauses (a) and (b)

Review of the medication incident reports for a three month period were completed by inspectors #194 and #672. A total of eighteen medication incidents were reported in this period. Eleven of the eighteen medication incidents involved high risk medications.

During interview ADOC #107 indicated that the medication incident reports were not analyzed. Review of the eleven medication incident reports completed by inspectors #194 and #672 indicated that only three medication incidents had any type of corrective action taken. [s. 135. (2)]

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. (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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 :

1. The licensee failed to ensure that the written plans of care set out clear direction to staff and others who provide direct care to resident #005 related to responsive behaviours, resident #021 related to bathing and resident #015 related to morning routine.

Log #034722-16 involving resident #005

A Critical Incident was submitted for an incident of responsive behaviour involving resident #005. The CI described that resident #005 was witnessed by staff exhibiting responsive behaviour towards resident #009 resulting in injury.

Interview with RPN #131 was conducted related to resident #005's responsive behaviours. RPN #131 indicated that resident #005's behaviour is very unpredictable. Resident #005 can exhibit behaviours when attempts are made to redirect the resident.

PSW #140 indicated during interview that resident #005's responsive behaviours will escalate if the resident is placed in a congested or high traffic areas. PSW #140 indicated during same interview that staff will try to distract or redirect resident #005 to prevent the behaviour from escalating.

PSW #135 indicated that if resident #005' body language becomes aggressive staff will attempt to monitor the resident closely and redirect. PSW #135 indicated that this strategy is usually effective if implemented in a timely manner.

RPN #133 indicated that resident #005's behaviours are very unpredictable. RPN #133 indicated during the interview that resident #005 was prescribed PRN medication if required. RPN #133 indicated that staff try to provide a "clear path" for resident #005 when exhibiting responsive behaviours.

Review of the plan of care for resident #005 for an identified period does not indicate the responsive behaviour or provide clear direction on how to manage the behaviour as described by RPN #133, #131, PSW #135 and #140.(194)

Related to resident #021

During an interview with Inspector #607 resident #021's family member expressed a concern related to bathing practices.

Review of resident #021 plan of care by Inspector #607 indicated the resident required one person physical assistance with bathing due to cognitive impairment.

Review of the written plan of care indicated that the resident #021 is provided a shower on a Tuesdays and Saturdays. The bath sheet used by Personal Support Workers (PSW) indicated resident #021 received a bath on Wednesdays and Saturdays.

Resident #021 who is cognitively impaired was unable to speak to the bathing routines, but was observed by inspector #607 to be appropriately groomed.

Interview with PSW #103 indicated that the written plan of care is incorrect as the resident #021 receives a bath Wednesday and Saturdays.

Interview with RPN #101 indicated the written plan of care should have indicated that resident #021 received baths Wednesdays and Saturdays and this was an oversight. (607)

Related to resident #015

During interview PSW #124 indicated that resident #015 could exhibit responsive

behaviours during care. PSW #124 indicated that all care provided to resident #015 is completed with the assistance of two staff members related to responsive behaviours. PSW #124 indicated that resident #015 is not awoken first thing in the morning, is allowed to sleep until the resident awakens independently, and care is provided to the resident slowly, in stages.

During interview PSW #139 informed Inspector #672 that resident #015 can be resistive to care.

Review of the plan of care for resident #005 for the identified period does not indicated any responsive behaviour towards co residents or provide clear direction on how to manage the resident's behaviour as described by RPN #133, #131, PSW #135 and #140. The plan of care for resident #021 did not provided clear direction to staff who provide direct care to the resident #021 as to when the resident receive baths. The plan of care does not provide clear direction for resident #015 to remain in bed until later in the day , does not provide direction about resident #015 responsive behaviour, requiring two staff to complete care. [s. 6. (1) (c)]

2. The licensee has failed to ensure that resident #021's plan of care was based on an assessment of the resident and the resident's needs and preferences.

In an interview the SDM for resident #021 indicated that the resident was being provided a shower when the resident's preference was a bath.

A review of resident #021's admission assessment indicated that resident #021 preferred baths.

A review of resident #021's admission written plan of care and current plan indicated that resident #021 receives a shower twice weekly.

A review of the resident's clinical health records failed to identify documented records to indicated that resident #021 had been re-assessed for bathing preferences.

During an interview with PSW #121 it was indicated that the resident was always provided a shower and PSW #121 was not aware that the resident's preference was a bath.

During an interview with RPN #120 and ADOC #107 it was indicated that if a resident

identified upon admission that his/her preferences is a bath, the home's expectation is that this should be honored, as long as it is safe for the resident. ADOC #107 further indicated there was no documentation that resident #021 was assessed for a bathing preferences.

The licensee failed to ensure that resident #021's plan of care was based on an assessment of the resident and the resident's needs and preferences, as the resident is receiving a shower when indicated preference was a bath. [s. 6. (2)] (607) [s. 6. (2)]

3. Resident #009 was identified as a high risk for falls as indicated by the comprehensive falls assessment completed quarterly.

Progress notes for resident #009 indicated:
On an identified date, resident #009 was found sitting on floor in the washroom. The resident was trying to go to the washroom. The resident complained of pain in right hip and knee and was transferred to hospital.
The following day, resident #009 was diagnosed with an injury.
Two days later, resident #009 was assessed by physiotherapist and was provided with ambulation and transferring equipment.

Review of resident #009's plans of care pre and post the fall incident indicated:
- Risk for falls characterized by history of falls/ injury, multiple risk factors related to: unsteady gait, postural hypotension, impaired balance, poor judgement regarding self-transferring and choosing improper footwear.
- Ensure both chair and bed alarms are in place and ensure they are working.
- Mobility - pushes self in wheelchair but also pushed by staff

On March 13, 2017 at 1415 hours, inspector #570 observed resident #009; the resident was seated in a specialized chair; the resident did not have an alarm in place while sitting in the specialized chair.

During interviews RPN #131, PSW #132 and PSW #140, all indicated that resident #009 should have a chair alarm in place.

The ADOC #105 indicated that a chair alarm should be in place when resident #009 is sitting in the chair as directed in the plan of care.

Resident #009 was not provided care as specified in the plan of care related to the use of

chair alarm, as part of the falls management interventions for the resident. [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 by ensuring that the plans of care for residents in the home
- provide clear direction to staff and others who provide direct care to residents related to responsive behaviours
- based on an assessment of the residents needs and preferences related to bathing
- are provided care as specified related to falls, to be implemented voluntarily.

WN #3: 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 failed to ensure drugs are administered to residents in accordance with the direction for use specified by the prescriber.

Review of the eigtheen medication incident reports identified for a three month period was completed by inspectors #672 and #194. Nine of the eighteen medication errors identified residents not being administered medications as specified by the prescriber. The medications errors involving high risk medications are listed below;

Review of resident #053 medication review report on an identified date indicated that resident #053 was prescribed an analgesic by mouth once per day.

Medication incident report involving resident #053 was reported on an identified date for medication error occurring the previous day. The incident report indicated that RPN #114

self reported administering the incorrect dosage of the analgesic to resident #053. RPN #114 indicated to inspector #672 that resident #053 did not have a specific assessment completed related to the error in medication, indicating that resident #053 was receiving this medication ongoing and did not notice any changes related to the resident's pain over the two days.

Review of resident #028's Medication Review Report, on an identified date indicated that resident #028 was ordered an analgesic. The order provided specific guidelines on how to apply the medication.

Review of resident #028's Medication Administration Record (MAR) indicated that on an identified date RPN #146 signed the MAR as having administered the analgesic.

A medication incident report was completed for a medication incident which occurred three days previously. The incident report indicated that, when RPN #148 was administering the analgesic to resident #028, it was noted that the analgesic that had been applied previously by RPN #146 was not applied as prescribed, resulting in an incorrect dosage of analgesic being administered.

Review of the Medication Review Report indicated that resident #031 was ordered medication by mouth once per day.

A medication incident report was completed by RPN #114 for a medication incident which involved resident #031. The incident report indicated that RPN #102 had signed the Medication Administration Record (MAR) as having given the medication, when the medication had not been administered to the resident. Therefore resident #031 did not receive his prescribed medication.[s. 131. (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 ensuring that drugs are administered to residents in accordance with the direction for use specified by the prescriber., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Related to Medication management system, Under O. Reg 79/10, s. 114(1) Every licensee of a long term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

Medication Administration and Documentation - "Medication Incidents" Policy # 4.15 dated August 1, 2015 indicated;
Page 3 of 5
1. Complete a resident assessment and chart in progress notes if the incident has reached the resident.
Page 4 of 5
3. Initiate a Medication incident/near miss report
-Effect on Resident
-Follow up actions taken
5. Notify the resident or POA for any incidents reaching the resident and any follow up actions taken
7. The Director of Care of Pharmacy Manager, as appropriate, investigates the medication incident, identifying factors contributing to the incident and documents the findings on the Medication Incident/Near miss report form.
8. The Director of Care of Pharmacy Manager, as appropriate, determines corrective

actions to be taken to reduce the risk of similar incident occurring in the future.
9. All Medication Incidents/Near Misses are reported, complied and analyzed and the results of the this analysis presented tot he Professional Advisory Committee. The evaluation of the medication incidents is used to recommend changes to the medication management system to reduce and prevent future medication incidents from occurring. Any changes implemented are monitored for effectiveness.

Medication Administration and Documentation - "Documentation of Narcotic and Controlled Medication " Policy # 4.19 dated August 1, 2015 indicated;
page 1 of 2
5. During each shift change, the outgoing and oncoming registered staff shall count all narcotics and sign on Form 10.8 "Shift change Narcotic/Controlled drug count record".
6. Any count or documentation discrepancies noted on the Resident Count Care of Shift Change Narcotic/ Controlled Drug count Record must be brought to the attention of the Director of Care's or DOC designates attention as soon as possible.

Medication Administration and Documentation - "Medication Administration Pass" Policy # 4.6 dated August 1, 2015 indicated;
page 2 of 2
11. Stay with the resident to ensure the medication has been swallowed.

Medication Administration and Documentation - "Medication Administration and Documentation Overview" Policy # 4.1 dated August 1, 2015 indicated;
Page 1 of 3
3. All medication must be administered to residents according to the directions for use specified by the prescriber.
6. The "Eight Rights" of medication administration are followed in accordance with Practice guidelines. Right resident, medication , reason, dose, route, frequency, site and time.

Medication Administration and Documentation - "Receiving Narcotic and Controlled Medications" Policy # 6.8 dated August 1, 2015 indicated;
Page 2 of 2
8. Medications stored in the narcotic lock box are counted by two registered staff at each shift change (or anytime the key for the lock box changes hands). The two staff shall include a registered staff member from the current shift and a registered staff from the on-coming shift. Both staff members shall reconcile the Shift Change Narcotic/Controlled Drug count Record with the actual quantity of the medication in the cared and the

quantity noted on the Resident count Card.
10. The home is responsible for a monthly audit/eAudit of the daily count sheets for narcotic and controlled substances to determine if there are any discrepancies.

Eighteen medication incident reports were reviewed by inspectors #194 and #672 for a three month period. Eleven of the eighteen medication incidents reported involved high risk medications.

All eleven medication incidents reported were reviewed by the inspectors. Review of the progress notes for the identified residents as well as interviews with RPN #101, #114, #149 and #143 involved in the medication errors were completed. The clinical health records did not have evidence that any assessments of the residents were completed following the medication incidents. One out of the eleven medication incident reports reviewed indicated that the POA had been notified of the medication error. Ten of the eleven medication error reported indicated that the wrong dose was provided to the resident or the medication was not provided, one incident involved a resident hoarding medications.

During interview with Inspector #672, ADOC #107 indicated being responsible for medication incidents in the home. ADOC #107 indicated to inspector #672 receiving the medication incidents reports and prior to the Professional Advisory Meetings (quarterly) would identify the information in a chart form for the team. ADOC #107 indicated that the RN's on the unit were responsible for follow up with registered staff involved in the medication incidents and then RN's would provide the medication incident report to ADOC #107. Three of the eleven medication incidents reviewed indicated a follow up with staff following the medication error. ADOC #107 indicated during same interview with inspector #672 that there have not been any evaluations or analysis of the medication errors reported prior to PAC quarterly meetings.

During interviews with inspector #672 on March 20, 2017, RPN #114, #149, #101, #129, #131 and #147 indicated that when they completed reconciliation of the Narcotic count, the on-coming registered staff were not present. The current staff RPN's would complete the reconciliation of the Narcotic count with RPN from another unit on the same shift. RPN #114, #101 and #149 indicated that when the reconciliation of the Narcotic Count was being completed the "Resident Count Card" was not reviewed at the time of the end of shift . [s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident-staff communication and response system is available in every area accessible by residents.

The Breezeway lounge area located in the second floor in between Blacklock house and Symons house home areas was noted to have no resident-staff communication and response system. The area included sofas, chairs and CD music player for residents use.

Residents were observed sitting in the Breezeway lounge area during the RQI inspection period from March 6-10 and March 13-17, 2017.

On March 17, 2017 interview of Environmental Services Manager (ESM) indicated that the Breezeway lounge area is a resident area with sofas and chairs for residents' use. The ESM indicated that he was not aware that the area was not equipped with resident-staff communication system. [s. 17. (1) (e)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any written complaints that have been received concerning the care of a resident or the operation of the home be immediately forwarded to the Director.

During an interview, resident #021's family member informed the Inspector that a complaint had been sent to the home related to several resident care issues. In an interview RPN #103, indicated that a complaint was brought forward to the home via email in regards to several care areas for resident #021.

A review of the home's complaint file indicated that the above concerns related to the resident care areas were brought forward to the home by resident #021's family member and the SDM on an identified date. The concerns brought forward by resident #021's family member were in writing via email. Further review of the home's Complaint Form indicated that the email concern was being treated as verbal complaint.

A review of the Licensee Concerns or Complaints policy with no identified number dated December 2016 page 3/3 directs:
Where the Long-Term Care Homes Act specifies, The Director of Care or designate shall also forward the complaint or concern to the ministry of Health and Long-Term Care in addition to the appropriate corresponding report.

During an interview the DOC indicated that home's expectation is that written complaints be forwarded within 10 days to the attention of the Director. The DOC further indicated this was not done for the above identified concerns, as the complaint was treated as a verbal complaint and not as a written complaint. The DOC indicated that the care concerns involving resident #021 were investigated by the home.

The licensee has failed to ensure that a written complaint involving resident #021 related to the care of the resident, was immediately forwarded to the Director. [s. 22. (1)]
(607) [s. 22. (1)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Log #021064-16 involving resident #051:

Review of healthcare records of resident #051 indicated the resident had multiple diagnoses and that the resident has since been discharged from the home.

During the review of resident #051 healthcare records,a progress note by RN #154 indicated a family concerns with the resident's toileting / continence care needs.

On March 16, 2016 interview with the Director of Care (DOC) indicated that she was not aware of the concern from resident #051's SDM. The DOC indicated that the documented staff communication to the resident would constitute as alleged or suspected neglect. The DOC further indicated that the incident should have been investigated and reported to the MOHLTC but it was not. The DOC indicated that RN #154 did not report that complaint, therefore the allegation was not reported and was not investigated.

The Director was not notified of the alleged abuse/neglect reported to RN #154 on the identified date.

This noncompliance is issued as WN under s.24 for an incident that occurred prior to compliance order for LTCHA, 2007 s.19 included s.24 under report # 2016_397607_0016 with a compliance date of January 18, 2017. [s. 24. (1) 2.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #021 is bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

During an interview resident #021's SDM indicated that the resident often had body odours and that the resident was not receiving scheduled baths.

A review of the resident's written plan of care indicated that the resident received a shower twice a week.

A review of resident #021's clinical health records indicated there was no documentation on three specific dates during a one month period, of the resident receiving a shower.

During an interview PSW #102 indicated that resident #021 was not provided showers on the above identified dates, as they may have been short staff.

During an interview RPN #120 indicated if a PSW is unable to provide a shower or bath to a resident, it should be documented and reported to the nurse in charge, as well as communicated to the incoming shift so that the resident's bath can be accommodated.

During an interview the DOC indicated that the home's expectation is, if a resident missed a bath because of case load concerns, then every attempt and arrangements must be made to ensure the resident is accommodated to receive the missed bath.

The Licensee failed to ensure that resident #021 is bathed, at a minimum, twice a week by the method of his or her choice, as the resident had three missed baths in a one month period.
[s. 33. (1)] (607) [s. 33. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's desired bedtime and rest routine supported and individualized to promote comfort, rest and sleep.

During an interview resident #021's SDM informed the inspector that the resident's family member came to visit on an identified date. The family member reported assisting resident #021 to bed at 2030 hours as the resident had indicated being tired. Resident #021's family member indicated in an e-mail to the licensee being informed by staff that the resident could not go bed, as it was customary routine by the staff to assist resident #021's roommate to bed prior to resident #021.

Resident #021's current written plan of care indicated that the resident prefers to go to bed at 2000 hours and if put to bed earlier will get up multiple times.

During an interview PSW #104 indicated making the above statement to resident #021's family member . The PSW #104 further indicated not being aware of resident #021's preferred bedtime of 2000 hours.

In an interview RPN #103 indicated that resident #021's roommate usually goes to bed prior to the resident and this was a common routine by the unit staff. RPN #103 further indicated that if resident #021's roommate goes to bed after resident #021, the roommate will often disrupt the resident. RPN #021 indicated that resident #021 usually goes to bed between 2030 and 2100 hours.

The licensee failed to ensure that on the identified date, resident #021 desired bedtime and rest routine was supported and individualized to promote comfort, rest and sleep. [s. 41.] [s. 41.]

Issued on this 8th day of May, 2017

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

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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHANTAL LAFRENIERE (194), CATHI KERR (641), JENNIFER BATTEN (672), JULIET MANDERSON-GRAY (607), SAMI JAROUR (570)
Inspection No. / No de l'inspection :	2017_603194_0010
Log No. / Registre no:	002756-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 20, 2017
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

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. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,

(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Order / Ordre :

a) Develop and implement an effective formal monitoring process to evaluate medication administration processes to promptly identify and address medication incidents to prevent re-occurrence and avoid adverse medication incidents (WN#3)

b) Implement immediate actions for medication incidents reported, specifically with high risk drugs.(WN#1)

c) Provide formal education for Registered staff related to Medication Policies specifically;

-Medication Incidents Policy 4.15
-Documentation of Narcotic and Controlled Medication Policy # 4.19
-Medication Administration Pass Policy #4.6
-Medication Administration Documentation Overview Policy #4.1
-Receiving Narcotic and Controlled Medications Policy #6.8 (WN #4)

b) Analyze the home's medication incident reports monthly to determine corrective action and medication trends for the purpose of reducing medication incidents, until such time as compliance is achieved.(WN#1)

Grounds / Motifs :

1. Review of the medication incident reports for a three month period were completed by inspectors #194 and #672. A total of eighteen medication incidents were reported in this period. Eleven of the eighteen medication incidents involved high risk medications. The following medication incidents also identified residents that did not receive medications as prescribed. (see WN #3). The high risk medications are dispensed by the pharmacy provider with Individual Narcotic Count Cards for a seven day period. Medication errors were noted to be identified at the end of the seven day period when medications were not signed for by the Registered staff and remained in the medication cart. The medication errors reviewed did not have assessments completed for the identified residents, as the medication errors were not identified for a number of days after the medication incidents occurred.(See WN #1)

Review of resident #053 medication review report for an identified date indicated that resident #053 was prescribed an analgesic by mouth once per day.

Review of resident #053's Medication Administration Record (MAR) indicated that on an identified date RPN #114 signed the MARs as having administered

the medication.

A medication incident report was submitted for a medication error occurring on the previous day. The incident report indicated that RPN #114 self reported administering the incorrect dose of the medication to resident #053.

During interview with inspector #672 on March 20, 2017 . RPN #114 explained that resident #053 had a routine dose of medication prescribed, three times a day as well as a different dosage of the same medication at noon, and an as needed dosage of the medication (PRN) in the medication cart. RPN #114 indicated selecting the wrong medication card in the medication cart and administered the incorrect dosage of the medication resident #053. RPN #114 indicated to inspector #672 during the same interview that resident #053 did not have a specific assessment completed related to the medication error, indicating that resident #053 was receiving this medication ongoing and the RPN did not notice any changes related to the resident's condition during the identified period.

Review of resident #028's Medication Review Report, on an identified date indicated that resident #028 was ordered an analgesic. The order provided specific guidelines on how to apply the medication.

Review of resident #028's Medication Administration Record (MAR) indicated that on an identified date RPN #146 signed the MAR as having applied the analgesic.

A medication incident report was completed on an identified date, for a medication incident which occurred three days previously. The incident report indicated that on an identified date, RPN #148 noted when administering the analgesic to resident #028, that the analgesic that had been applied previously by RPN #146 was not applied as directed resulting in an incorrect dosage of analgesic being administered. Review of the clinical health record for resident #028 was completed by inspector #194 with no evidence of an assessment related to the medication error documented. The clinical health record did not indicate any changes in resident #028's pain during the identified period.

On the back of the Medication Incident/Near Incident Report, RPN #146 documented that the incident occurred due to "Unfamiliar with the unit and the shift. Didn't read the order properly".

Review of resident #031's Medication Review Report, on an identified date indicated that resident #031 was ordered a medication by mouth once per day.

Review of resident #031's Medication Administration Record (MAR), indicated that on an identified date, RPN #102 had signed the MAR as having administered the medication.

A medication incident report was completed by RPN #114, for a medication incident which had occurred on two days previously. The incident report indicated that, RPN #102 had signed the Medication Administration Record (MAR) as having administered the medication, but the medication had not been administered to the resident.

RPN #114 indicated during interview with Inspector #672 that a medication error was noted during the medication pass. RPN #114 noted that the Resident Count Card was off, further review through the MAR and the Resident Count Card sheet, indicated that the medication error occurred two days previously. RPN#102 had signed the MAR's as having given the medication, but there was an extra tab of the medication left in the card, and the administration had not been signed off as given on the Resident Count Card sheet. RPN #114 stated there was no need to complete a resident assessment, as resident #031 was quite independent, and would report to the staff if the resident was feeling that there was anything wrong. RPN #114 also stated that due to the incident being two days prior, that an assessment would not have necessarily benefited the resident.

Review of the clinical health records for residents #028, #031, #053 were completed by inspector #672 and #194 with no evidence of POAs or residents informed of the medication errors. The Clinical health records reviewed did not have evidence to support that any assessment of the residents had been completed related to the medication errors.

The SDM for resident #021 indicated that he/she was going over the resident #021's Medication Administration Records (MAR) and notice that a medication was not signed as being administered.

A review of the MARs for resident #021 for a period of three months was completed and indicated that there were eight incidents where resident #021's

medication was not signed as being administered.

Interview with RPN #102, indicated that the medications were administered to resident #021 but were not signed for.

During interview RPN #101 indicated having missed administering the scheduled medications.

In an interview ADOC #107 indicated that she had not received any medication incident reports involving resident #021 for the above identified months, and the home's expectation is that the registered staff self-report when there is a medication error as well as report this to the RN in charge of the unit.(607) [s. 135. (1)]

2. The licensee has failed to ensure that all medication incidents and adverse drug reactions are documented, reviewed and analyzed
(b) corrective action is taken as necessary, and
(c) a written record is kept of everything required under clauses (a) and (b)

Review of the medication incident reports for a three month period were completed by inspectors #194 and #672. A total of eighteen medication incidents were reported in this period. Eleven of the eighteen medication incidents involved high risk medications.

During interview ADOC #107 indicated that the medication incident reports were not analyzed. Review of the eleven medication incident reports completed by inspectors #194 and #672 indicated that only three medication incidents had any type of corrective action taken. [s. 135. (2)]

A Compliance Order under O. Reg. 79/10, s. 135 (1)(2) is being issued related to the number of medication errors and potentially high risk medications involved in the medication incidents reported for the period of December 2016 to February 2017. Eleven medication incidents involving high risk medications were reported during the identified period. There was no evidence of assessments completed for residents involved, POA's were not notified, no immediate actions were taken related to registered staff and no evaluations for the medication errors was evident other than data collection of statistical purposes. A Written Notification was issued to the home in July 28, 2015 under Report # 2015_396103_0046 for s. 131(2) for not administering medication to

residents as prescribed. (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2017

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 20th day of April, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Chantal Lafreniere

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