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 # / No de registre	Type of Inspection / Genre d'inspection
Nov 28, 2017	2017_603194_0027	014935-17	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

CHANTAL LAFRENIERE (194)

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): November 14, 15 and 16, 2017

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Dietitian (RD), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Dietary Manager (DM) and Dietary Aide (DA)

The inspector reviewed the resident's clinical health records, Food temperature records, relevant policies, practices related to written complaints,

The following Inspection Protocols were used during this inspection:
Dining Observation
Personal Support Services
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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. (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 has failed to ensure that the care set out in the plan of care is provided to the resident #001 as specified in the plan related to bathing

Log #014935-17 involving resident #001

The plan of care for resident #001 for a specified date indicated that resident was to be bathed twice weekly. Family had requested that resident #001 be provided a tub bath.

A MEMO dated for a specified date was delivered to staff on the unit explaining the process developed for providing a tub bath for resident #001.

Interview with family member was completed by inspector #194. The family member has expressed that resident #001 has always bathed in a tub which was the residents preference. The family member has indicated that this preference related to bathing has been reported to the home.

Review of the documentation in Point of Care (POC) related to bathing for resident #001 for the period of three months was completed.

The first month's bathing records indicated six of the eight baths were provided as showers

The second month's bathing records indicated eight of the nine baths were provided as showers.

the third month's bathing records indicated six of the eight baths were provided as showers

Interview with PSW #107 and RPN #108 were conducted separately related to the bathing process for resident #001. Both staff members expressed that resident #001did not like having a tub bath and preferred the shower and that staff had been showering resident #001.

The licensee failed to provide the care set out in the plan of care for resident #001 related to bathing. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident #002 related to 1:1 monitoring.

Log #014935-17 involving resident #001

During interview on November 16, 2017, DOC explained that during a specified period of time, 1:1 monitoring for resident #002 had been implemented to manage the resident's responsive behaviours.

On a specific date, 1:1 monitoring was in place for resident #002. The incident report reviewed and progress notes indicated that resident #002 exhibited a responsive behaviour towards resident #001. Resident #001 was not injured.

One week later, 1:1 monitoring was in place for resident #002. The incident report and progress notes indicated that resident #002 exhibited a responsive behaviour towards resident #001. Resident #001 was not injured.

The licensee failed to provided the care set out in the plan related to 1:1 monitoring for resident #002. [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 care set out in the plan of care for resident #001 is provided as specified in the plan related to bathing. The plan of care set out in the plan of care for resident #002 is provided as specified in the plan related to 1:1 monitoring, to be implemented voluntarily.

WN #2: 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: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that food and fluids were served at a temperature that is both safe and palatable to the residents.

On a specific date, a companion was sitting with resident #001 during the lunch meal. The companion identified to PSW staff that the meal served to resident #001 was frozen.

The Dietary Manager (DM) indicated that upon the homes investigation into the incident that temperature for the meal item in the servery had not been taken by DA #113. DM indicated that Dietary Aide (DA) #113 explained during the interview that cold foods never had temperatures taken.

During an observation with DM and inspector #194 on a specific date during the lunch meal service, DA #113 was asked why the temperature for a specific menu item had not been taken. DA #113 replied that cold foods did not have temperatures taken.

Review of the food temperature forms completed by DA #113 for two specific dates, during the lunch meals were reviewed. On both identified dates DA #113 did not take the temperatures of the specific menu items.

Review of Policy "Food Handling" was completed by inspector #194 and directed;
-cold on hold or thaw temperatures are to be 40 degrees Fahrenheit or 4 degrees Celsius.

Review of Policy "Temperature Control" was completed by inspector #194 and directed;
-The designated Dietary Services staff member taking the temperatures, shall record all temperatures on the temperature log. The designate Dietary Services staff is to note and report any discrepancies with the established criteria to the Dietary Services Manager or designate who will take the appropriate action.

On a specific date resident #001 was served a menu item that was not palatable. [s. 73. (1) 6.]

WN #3: 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:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that written complaints made to the licensee or a staff member concerning the care of a resident #001 has been investigated and response provided within 10 business days of receipt of the complaint

Written complaints related to provision of care were received over a one month period from family of resident #001.

A meeting with DOC, ADOC, Power of Attorney (POA) and family member of resident #001 was held on a specific date to discuss the concerns reported.
The meeting did not address five individual concerns identified by the family member in the written complaint letters.

The licensee did not provide a response to the complainant within 10 business days of the complaints related to concerns identified related to care of resident #001 [s. 101. (1) 1.]

Issued on this 28th day of November, 2017

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

Original report signed by the inspector.