Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 1, 2021	2021_643111_0001	019019-20, 019031-20, 020681-20, 020838-20, 021502-20, 022693-20, 024262-20, 001078-21	Critical Incident System

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 7-8, 11-14 and 18-19, 2021.

There were multiple critical incidents and a follow-up inspection completed concurrently during this inspection as follows:
-follow-up related to abuse.
-Four CIRs related to alleged staff to resident abuse and/or neglect.
-Two CIRs related to resident to resident abuse.
-One CIR related to an outbreak.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping (HSK), Dietary Aides (DA), Activation, Environmental Staff, Scheduling Clerk and residents.

During the course of the inspection, the inspector: reviewed resident health records, toured the home, reviewed infection surveillance records, reviewed staff schedules and reviewed the following policies: Responsive Behaviours, Prevention, Reporting and Elimination of Resident Abuse and Infection, Prevention and Control.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **5 VPC(s)**
- **3 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	2020_640601_0022	111

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	Légende 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. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the resident's SDM and any other person specified by the resident, were immediately notified upon becoming aware of a witnessed incident of abuse of resident #010 caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

A staff member witnessed resident #009 being abusive to resident #010. Resident #010 was upset after the incident and expressed fear of resident #009. The incident was reported to an RPN and was investigated by ADOC #100. Both the RPN and the ADOC confirmed they did not report the incident to the SDM of resident #010.

Sources: CIR, progress notes of resident #010, home's investigation and interview of staff.

2. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of suspected neglect of resident #003.

A staff member had left resident #003 unattended in a specified area and reported to an

RPN, that the resident was demonstrating their usual responsive behaviour. The RPN reported the responsive behaviour to the SDM. The RPN later discovered the resident had been left unattended and neglected and reported the incident to RN #105. Both the RPN and the RN confirmed the SDM was not informed of the suspected neglect, despite the CIR indicating that the SDM was notified.

Sources: CIR, progress notes of resident #003, home’s investigation and interview of staff.

3. The licensee has failed to ensure that resident #003 and resident's SDM, were notified of the results of the alleged staff to resident neglect investigation immediately upon the completion.

An alleged staff to resident neglect incident occurred towards resident #003. The home’s investigation was completed but had no indication of a conclusion. ADOC #101 indicated they completed the investigation and concluded the allegation was founded and the SDM had not been informed of the results of the investigation.

Sources: CIR, progress notes of resident #003, home’s investigation and interview of staff.

4. The licensee has failed to ensure that resident #005 and the resident's SDM, were notified of the results of a witnessed staff to resident abuse investigation, immediately upon the completion.

An RN witnessed staff to resident abuse by a PSW towards resident #005. The home’s investigation was completed and concluded as founded. ADOC #101 confirmed they completed the investigation and the SDM had not been informed of the results of the investigation.

Sources: CIR, home’s investigation and interview of staff.

5. The licensee has failed to ensure that resident #006 and #007’s SDM's were notified of the results of the witnessed resident to resident abuse investigation, immediately upon the completion.

Resident #006 was witnessed by a staff member, abusing resident #007. The home’s investigation was completed and concluded as founded. ADOC #100 confirmed they

completed the investigation and although resident #006 was provided with the outcome, the SDM's of resident #006 and #007 were not informed of the results of the investigation.

Sources: CIR, progress notes for resident #006 and #007, home's investigation and interview of staff.

6. The licensee has failed to ensure that resident #010's SDM, was notified of the results of a witnessed resident to resident abuse investigation, immediately upon the completion.

A staff member witnessed resident #009 being abusive towards resident #010. ADOC #100 confirmed they completed the investigation, the investigation was concluded as founded and could not verify that they informed the SDM of resident #010 of the outcome of the investigation.

Sources: CIR, progress notes of resident #010, home's investigation and interview of staff.

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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

The licensee has failed to ensure that the designated staff member to co-ordinate the infection prevention and control (IPAC) program had education and experience in infection prevention and control practices including: infectious disease, cleaning and disinfection, data collection and trend analysis, reporting protocols and outbreak management.

ADOC #100 confirmed they were the designated IPAC lead and did not have any formal training in IPAC practices. They also confirmed they did not complete any ongoing audits related to IPAC, despite being identified on the IPAC assessment completed by the local hospital and the home being in outbreak for COVID-19.

Sources: CIR and interview with staff.

2. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program related to appropriate signage for precautions and PPE.

The Inspector observed the following throughout the home on a specified date:
-resident #011 and #012 had a sign posted for contact and droplet precautions and PPE station. There was no indication which of the two residents were on isolation, the PPE station did not have the required PPE and there was no discard bin available. Three staff working on the unit had no knowledge that either resident was on isolation and thought

the PPE station was left from a previous outbreak that ended the week before.
-resident #013 had a sign posted for contact and droplet precautions, and had a PPE station that had no masks. There was also no discard bin available. A PSW was observed entering the room to interact with the resident, did not don appropriate PPE or doff correctly upon exiting the room or complete hand hygiene. The PSW confirmed awareness the resident was on isolation for contact and droplet precautions and confirmed the PPE station did not contain the required PPE. The PSW stated, “they are only given one mask and told to wear the same mask for their entire shift”.
-resident #014 had a PPE station but no sign posted to indicate the type of precautions in place. A PSW indicated no awareness of the resident being on isolation precautions.
-resident #015 had a PPE station and a discard bin, but no sign to indicate type of precautions in place. The PPE station did not contain the required PPE. ADOC #100 indicated the resident was on contact and droplet precautions and was unaware there was no precautions sign posted or that the PPE station did not contain the required PPE.
-resident #016 had a sign posted for contact and droplet precautions and a PPE station that only contained gloves.
-an identified room was observed to have no name to indicate which resident resided in the room. There was a sign posted for droplet and contact precautions and a PPE station, which did not contain any masks. Two staff working on the unit confirmed resident #018 resided in the specified room, was aware of the contact and droplet precautions, and that the PPE station did not contain the appropriate PPE. They both indicated they were told that they “only get one mask to wear for their entire shift”.
-throughout the home, there were a number of large wall mounted fans which were turned on, and should not have been turned on during a COVID-19 outbreak.

In addition, the IPAC assessment completed by the local hospital identified the lack of IPAC audits, in order to determine staff compliance with hand hygiene, routine practices and PPE use. ADOC #100 confirmed there was no IPAC auditing process in place and on a specified date, the home was declared in COVID-19 outbreak by Public Health. By failing to ensure that the staff participated in the implementation of the infection control program, and the home having two COVID-19 outbreaks, there was a risk to the residents of contracting infection.

Sources: two CIRs, observations, review of the home's Infection Prevention and Control policy and staff interviews.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

The licensee has failed to ensure that their prevention of abuse policy was complied with for resident #003.

Resident #003 had been found neglected by a staff member. The incident of staff to resident neglect was reported to an RPN and an RN, later the same day. Both the RPN and RN confirmed they were to document factual information for any alleged incidents of staff to resident neglect in the residents health record, and confirmed they did not follow the home's prevention of abuse policy. Failing to document factual information of alleged staff to resident neglect and including who was notified, dismisses that incidents have occurred and impacts the home's ability to complete a proper investigation.

Sources: CIR, progress notes of resident #003, Prevention, Reporting and Elimination of Resident Abuse policy and interview of staff.

2. The licensee has failed to ensure that their prevention of abuse policy was complied with for resident #001.

Resident #001 was heard screaming during their care, which was unusual and the resident later reported to an RPN of improper care and rough handling by a PSW. The RPN reported the allegations to two RNs. There was no documented evidence in the resident's health record regarding the incident or allegations. The home's Prevention, Reporting and Elimination of Resident Abuse policy indicated Registered staff were to

document factual information in their health record for any alleged, suspected or witnessed incidents of abuse and/or neglect. One of the RNs who was notified of the allegation no longer worked in the home. Both the RPN and the second RN confirmed they were to document factual information any alleged or suspected incidents of staff to resident improper care or rough handling in the residents health record and confirmed the home's prevention of abuse policy was not followed. Failing to document factual information of alleged improper care or rough handling of a resident and including who was notified, dismisses that incidents have occurred and impacts the home's ability to complete a proper investigation.

Sources: CIR, progress notes of resident #001, Prevention, Reporting and Elimination of Resident Abuse policy, and interview of staff.

3. The licensee has failed to ensure that their prevention of abuse policy was complied with for resident #009 and #010.

A PSW witnessed resident #009 being abusive towards resident #010, that resulted in resident #010 being upset and fearful of resident #009 and reported the incident to an RPN The RPN confirmed they were notified of the witnessed resident to resident abuse incident, had not documented the incident until the following day and did not document factual information regarding the incident as per the home's prevention of abuse policy. ADOC #100 also confirmed they did not complete a thorough investigation, as they did not complete the required forms or obtain statements from staff who were present or witnessed the incident, as per the homes prevention of abuse policy.

Sources: CIR, progress note of resident #009 and #010, home’s investigation and prevention, reporting and elimination of resident abuse policy and staff interviews.

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee has failed to ensure that the home was a safe and secure environment for its residents.

In accordance with the COVID-19 Directive #3 (for Long-Term Care Homes under the Long-Term Care Homes Act, 2007), indicated the LTCHs must immediately actively screen all staff, visitors and anyone else entering the LTCH for COVID-19. Active screening must include symptom screening and temperature checks, food and product deliveries dropped in an identified area and active screening of delivery personnel done prior to entering the LTCH. Upon entry to the home, the Inspector noted the screener was not wearing proper PPE, did not include all symptom screening questions and ensuring proper donning of PPE. Upon exiting the home, the Inspector had no screener present and the Inspector was able to leave the home without any active screening being completed. There was also an area on the lower level, where contractors or delivery personnel were able to enter the home and self-screen. By not completing proper active screening of all visitors entering and exiting the home, and ensure all visitors are wearing proper PPE, places the screener and the home at risk for COVID-19.

Sources: tour of the home and interview with an ADOC.

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 home was a safe and secure environment for its residents, to be implemented voluntarily.

WN #5: 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 :

The licensee failed to ensure that the plan of care was provided to resident #001 related to having access to personal items within reach and repositioning in bed.

Resident #001 required the use of a communication device and had limited mobility. On a specified date, the resident reported allegations of improper care and rough handling by two PSWs that resulted in the resident being upset and having pain. On a different date and time, the resident reported to an RN that they were not provided access to their personal items or communication device, which resulted in the resident being unable to report pain. On a specified date, the Inspector observed the resident without access to their communication device. Not providing the resident with their personal items or communication devices as per their plan of care, can impede the residents ability to communicate their needs or discomfort, and not ensuring proper repositioning of the resident can result in an injury.

Sources: two CIRs, home's investigation, resident #001 progress notes and care plan, interview with resident and interview with staff.

2. The licensee has failed to ensure the plan of care was provided to resident #003 related to falls and responsive behaviours.

Resident #003 was found on the floor, neglected for a period of time, by a PSW and the PSW reported to an RPN that the resident had been demonstrating responsive behaviours. There was no documented evidence of the incident in the residents health record. The resident's care plan indicated the resident was at risk for falls due to history of falls, demonstrated a specified responsive behaviour and staff were to ensure the residents personal needs were met, and the nurse was to document the incident based on their assessment. An RN and RPN confirmed resident #003 displayed specified responsive behaviours, staff were to assess the resident whenever the resident was found on the floor, report the incident to the RPN to immediately assess the resident, document the incident, as per their care plan and both confirmed the plan of care was not followed.

Sources: CIR, progress notes, Kardex and care plan of resident #003, home's investigation and interview of staff.

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #6: 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 :

The licensee has failed to ensure that the person having reasonable grounds to suspect improper care of resident #001, that resulted in harm or a risk of harm, immediately reported the suspicion and the information upon which it was based, to the Director.

Resident #001 was heard by an RPN screaming during care, which was unusual. Later the same day, the resident #001 reported alleged improper care and rough handling by two PSWs, that resulted in the resident being visibly upset and pain to a specified area. The RPN reported the allegations to two RNs and one of the RNs reported the allegations to ADOC #100 the following day. The allegations of staff to resident improper care and rough handling were not reported to the Director until a number of days later after the allegation was made. Not immediately reporting to the Director prevents proper follow-up.

Sources: CIR, progress notes of resident #001, home's investigation and interview of staff.

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 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, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

The licensee has failed to ensure that the appropriate police force was immediately notified of an alleged incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Resident #001 reported to an RPN an allegation of improper care and rough handling by two PSWs. The allegation was reported to two RNs. The investigation was initiated by one RN and completed by ADOC #100 and they both confirmed the police were not informed of the allegations.

Sources: CIR, home's investigation and interview of staff.

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 appropriate police force was immediately notified of an alleged incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

The licensee has failed to ensure that following the preliminary report, a final report was made to the Director within 21 days of an alleged staff to resident neglect of resident #003.

There was an alleged staff to resident neglect incident that had occurred towards resident #003. The home's investigation was completed on a specified date, the conclusion was not identified until a number of months later, and indicated the allegation was founded. ADOC #101 confirmed they did not update the report to the Director within 21 days.

Sources: CIR, home's investigation and interview with staff.

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 following the preliminary report, a final report is made to the Director within 21 days of an alleged, suspected or witnessed incident of abuse and or neglect of resident by anyone, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee has failed to ensure that resident #007 was protected from abuse by anyone.

A staff member witnessed resident #006 being abusive towards resident #007. A second incident occurred when another staff member witnessed resident #008 being abusive

towards resident #007. On a specified date, the Inspector was unable to locate resident #007 and an RPN later located the resident in another resident's room, with specified interventions not in place. The RPN indicated they could only monitor resident #007 when they had time due to working short-staffed.

Resident #007 had specified diagnoses and displayed specified responsive behaviours, putting them at risk for abuse. There were no interventions implemented for resident #007 after the first incident of abuse. After the second incident of abuse, interventions included monitoring of the resident but no indication how long the monitoring was to occur. BSO recommended specified interventions, but the care plan was never updated to reflect those interventions. A PSW was only aware of one incident of resident to resident abuse involving resident #007 and was unaware of resident #008's history of abuse or any residents that required heightened monitoring.

Resident #008 had a prior history of specified responsive behaviours towards residents when left unsupervised. The resident had specified interventions that were to be implemented to prevent abuse towards other residents. Following the abuse incident towards resident #007, additional interventions were to be implemented. The responsive behaviour policy also indicated specified assessments were to be completed for residents with high-risk responsive behaviours and the BSO staff member confirmed none of the specified assessments had been completed for either resident #007 or #008, confirmed only residents who demonstrated high-risk responsive behaviours within 24 hours, were communicated at the shift report and they did not monitor residents ongoing, who displayed high-risk responsive behaviours to ensure interventions were effective. The BSO staff member confirmed both resident's care plans had not been updated to indicated the type, frequency or who was responsible for completing the monitoring of the residents. There was actual harmful interactions between resident #007 and other residents (#006 and #008) and the interventions and triggers identified for such altercations, were not implemented or unclear.

Sources: observations and interviews with resident #006, #007 and #008, progress notes, care plan and assessment tools for resident #006, #007 and #008, review of the Responsive Behaviour policy (revised June 2015), and interview with staff.

Issued on this 17th day of March, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2021_643111_0001
Log No. / No de registre :	019019-20, 019031-20, 020681-20, 020838-20, 021502-20, 022693-20, 024262-20, 001078-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 1, 2021
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 :	William Detlor

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:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Order / Ordre :

The licensee must be compliant with O.Reg.79/10, s.97(2).

Specifically, the licensee must notify all resident's (where applicable) and their substitute decision makers, if any, of the results of the investigation into any alleged, suspected or witnessed abuse and/or neglect, immediately upon completion of the investigation.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of suspected neglect of resident #003.

A staff member had left resident #003 unattended in a specified area and reported to an RPN, that the resident was demonstrating their usual responsive behaviour. The RPN reported the responsive behaviour to the SDM. The RPN later discovered the resident had been left unattended and neglected and reported the incident to RN #105. Both the RPN and the RN confirmed the SDM was not informed of the suspected neglect, despite the CIR indicating that the SDM was notified.

Sources: CIR, progress notes of resident #003, home's investigation and interview of staff.

-The licensee has failed to ensure that resident #003 and resident's SDM, were notified of the results of the alleged staff to resident neglect investigation immediately upon the completion.

An alleged staff to resident neglect incident occurred towards resident #003. The home's investigation was completed but had no indication of a conclusion. ADOC #101 indicated they completed the investigation and concluded the allegation was founded and the SDM had not been informed of the results of the investigation.

Sources: CIR, progress notes of resident #003, home's investigation and interview of staff. (111)

2. The licensee has failed to ensure that resident #005 and the resident's SDM, were notified of the results of a witnessed staff to resident abuse investigation, immediately upon the completion.

An RN witnessed staff to resident abuse by a PSW towards resident #005. The home's investigation was completed and concluded as founded. ADOC #101 confirmed they completed the investigation and the SDM had not been informed of the results of the investigation.

Sources: CIR, home's investigation and interview of staff. (111)

3. The licensee has failed to ensure that resident #006 and #007's SDM's were notified of the results of the witnessed resident to resident abuse investigation, immediately upon the completion.

Resident #006 was witnessed by a staff member, abusing resident #007. The home's investigation was completed and concluded as founded. ADOC #100 confirmed they completed the investigation and although resident #006 was provided with the outcome, the SDM's of resident #006 and #007 were not informed of the results of the investigation.

Sources: CIR, progress notes for resident #006 and #007, home's investigation and interview of staff. (111)

4. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident, were immediately notified upon becoming aware of a witnessed incident of abuse of resident #010 caused distress to the

resident that could potentially be detrimental to the resident's health or well-being.

A staff member witnessed resident #009 being abusive to resident #010. Resident #010 was upset after the incident and expressed fear of resident #009. The incident was reported to an RPN and was investigated by ADOC #100. Both the RPN and the ADOC confirmed they did not report the incident to the SDM of resident #010.

Sources: CIR, progress notes of resident #010, home's investigation and interview of staff.

-The licensee has failed to ensure that resident #010's SDM, was notified of the results of a witnessed resident to resident abuse investigation, immediately upon the completion.

A staff member witnessed resident #009 being abusive towards resident #010. ADOC #100 confirmed they completed the investigation, the investigation was concluded as founded and could not verify that they informed the SDM of resident #010 of the outcome of the investigation.

Sources: CIR, progress notes of resident #010, home's investigation and interview of staff.

An order was made by taking the following factors into account:
Severity: There was actual risk of harm to the residents because the investigations determined they were all of the alleged, suspected or witnessed incidents of abuse and/or neglect were determined to be founded.
Scope: The scope of this non-compliance was widespread because all four incidents did not have the substitute decision makers (SDMs) notified of the outcomes of the investigations, immediately upon the conclusion.
Compliance History: the home had non-compliance to O.Reg. 79/10, s.97(2) and to a different subsection as follows:
-A voluntary plan of correction (VPC) was issued on January 27, 2020.
-A VPC was issued on June 19, 2019 to O.Reg. 79/10, s.97(1)(a). (111)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Mar 31, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with O.Reg 79/10, s. 229(4).

Specifically the licensee must do the following:
1. Ensure there is proper PPE available for staff to have an appropriate supply for staff to have safe changes in masks.
2. Ensure all caddies are stocked sufficiently with PPE.
3. Ensure signage is posted according to PH guidelines.
4. Implement an auditing schedule for PPE and hand hygiene to be conducted daily on all three shifts.
5.The IPAC lead has received training/education with current best practices for IPAC.

Grounds / Motifs :

1. The licensee has failed to ensure that the designated staff member to co-ordinate the infection prevention and control (IPAC) program had education and experience in infection prevention and control practices including: infectious disease, cleaning and disinfection, data collection and trend analysis, reporting protocols and outbreak management.

ADOC #100 confirmed they were the designated IPAC lead and did not have any formal training in IPAC practices. They also confirmed they did not complete any ongoing audits related to IPAC, despite being identified on the IPAC assessment completed by the local hospital and the home being in outbreak for COVID-19.

Sources: CIR and interview with staff.

2. The licensee has failed to ensure that staff participated in the implementation

of the infection prevention and control program related to appropriate signage for precautions and PPE.

The Inspector observed the following throughout the home on a specified date:
-resident #011 and #012 had a sign posted for contact and droplet precautions and PPE station. There was no indication which of the two residents were on isolation, the PPE station did not have the required PPE and there was no discard bin available. Three staff working on the unit had no knowledge that either resident was on isolation and thought the PPE station was left from a previous outbreak that ended the week before.
-resident #013 had a sign posted for contact and droplet precautions, and had a PPE station that had no masks. There was also no discard bin available. A PSW was observed entering the room to interact with the resident, did not don appropriate PPE or doff correctly upon exiting the room or complete hand hygiene. The PSW confirmed awareness the resident was on isolation for contact and droplet precautions and confirmed the PPE station did not contain the required PPE. The PSW stated, "they are only given one mask and told to wear the same mask for their entire shift".
-resident #014 had a PPE station but no sign posted to indicate the type of precautions in place. A PSW indicated no awareness of the resident being on isolation precautions.
-resident #015 had a PPE station and a discard bin, but no sign to indicate type of precautions in place. The PPE station did not contain the required PPE. ADOC #100 indicated the resident was on contact and droplet precautions and was unaware there was no precautions sign posted or that the PPE station did not contain the required PPE.
-resident #016 had a sign posted for contact and droplet precautions and a PPE station that only contained gloves.
-an identified room was observed to have no name to indicate which resident resided in the room. There was a sign posted for droplet and contact precautions and a PPE station, which did not contain any masks. Two staff working on the unit confirmed resident #018 resided in the specified room, was aware of the contact and droplet precautions, and that the PPE station did not contain the appropriate PPE. They both indicated they were told that they "only get one mask to wear for their entire shift".
-throughout the home, there were a number of large wall mounted fans which were turned on and should not have been turned on during a COVID-19

outbreak.

In addition, the IPAC assessment completed by the local hospital identified the lack of IPAC audits, in order to determine staff compliance with hand hygiene, routine practices and PPE use. ADOC #100 confirmed there was no IPAC auditing process in place and on a specified date, the home was declared in COVID-19 outbreak by Public Health. By failing to ensure that the staff participated in the implementation of the infection control program, and the home having two COVID-19 outbreaks, there was a risk to the residents of contracting infection.

Sources: two CIRs, observations, review of the home's Infection Prevention and Control policy and staff interviews.

An order was made by taking the following factors into account:
Severity: There was actual risk of harm to the residents because there was potential for possible transmission of infectious agents due to the staff not participating in the implementation of the
IPAC program.
Scope: The scope of this non-compliance was widespread because the IPAC related concerns were identified during observations on all units, and the non-compliance has the potential to affect a large number of the LTCH's residents.
Compliance History: the home has had non-compliance to different subsection in the past 36 months as follows:
-a Voluntary Plan of Correction (VPC) was issued to O.Reg.79/10, s.229(3) on December 3, 2020.
-a VPC was issued to O.Reg. 79/10, s. 229(5) on January 27, 2020. (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 05, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee shall ensure that LTCHA, 2007. s.20(1) is complied with.

Specifically, the licensee shall ensure that all Registered Staff document factual information on the residents progress notes regarding any alleged, suspected or witnessed abuse and or neglect of a resident, including who was notified, as per the home's Prevention, Reporting and Elimination of Resident Abuse policy.

Grounds / Motifs :

1. The licensee has failed to ensure that their prevention of abuse policy was complied with for resident #003.

Resident #003 had been found neglected by a staff member. The incident of staff to resident neglect was reported to an RPN and an RN, later the same day. Both the RPN and RN confirmed they were to document factual information for any alleged incidents of staff to resident neglect in the residents health record, and confirmed they did not follow the home's prevention of abuse policy. Failing to document factual information of alleged staff to resident neglect and including who was notified, dismisses that incidents have occurred and impacts the home's ability to complete a proper investigation.

Sources: CIR, progress notes of resident #003, Prevention, Reporting and Elimination of Resident Abuse policy and interview of staff. (111)

2. The licensee has failed to ensure that their prevention of abuse policy was complied with for resident #001.

Resident #001 was heard screaming during their care, which was unusual and the resident later reported to an RPN of improper care and rough handling by a PSW. The RPN reported the allegations to two RNs. There was no documented evidence in the resident's health record regarding the incident or allegations. The home's Prevention, Reporting and Elimination of Resident Abuse policy indicated Registered staff were to document factual information in their health record for any alleged, suspected or witnessed incidents of abuse and/or neglect. One of the RNs who was notified of the allegation no longer worked in the home. Both the RPN and the second RN confirmed they were to document factual information any alleged or suspected incidents of staff to resident improper care or rough handling in the residents health record and confirmed the home's prevention of abuse policy was not followed. Failing to document factual information of alleged improper care or rough handling of a resident and including who was notified, dismisses that incidents have occurred and impacts the home's ability to complete a proper investigation.

Sources: CIR, progress notes of resident #001, Prevention, Reporting and Elimination of Resident Abuse policy, and interview of staff. (111)

3. The licensee has failed to ensure that their prevention of abuse policy was complied with for resident #009 and #010.

A PSW witnessed resident #009 being abusive towards resident #010, that resulted in resident #010 being upset and fearful of resident #009 and reported the incident to an RPN. The RPN confirmed they were notified of the witnessed resident to resident abuse incident, had not documented the incident until the following day and did not document factual information regarding the incident as per the home's prevention of abuse policy. ADOC #100 also confirmed they did not complete a thorough investigation, as they did not complete the required forms or obtain statements from staff who were present or witnessed the incident, as per the homes prevention of abuse policy.

Sources: CIR, progress note of resident #009 and #010, home's investigation and prevention, reporting and elimination of resident abuse policy and staff interviews.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

An order was made by taking the following factors into account:
Severity: There was actual risk of harm to the residents because the investigations determined all of the alleged, suspected or witnessed incidents of abuse and/or neglect were founded and failing to document factual information of alleged staff to resident abuse and/or neglect, including who was notified, dismisses that incidents have occurred and impacts the home's ability to complete a proper investigation.
Scope: The scope of this non-compliance was widespread because all three incidents did not have the incidents documented or indications of who was notified as per the home's prevention of abuse policy.
Compliance History: the home had ongoing non-compliance to LTCHA, 2007, s.20(1) as follows:
-A Voluntary Plan of Correction (VPC) was issued on December 3, 2020, June 18, 2019 and February 26, 2018. (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Mar 05, 2021

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 1st day of March, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

Service Area Office /
Bureau régional de services : Central East Service Area Office