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 |
|---|---|---|---|
| Jun 9, 2021 | 2021_885601_0010 | 026060-20, 001449-21, 004557-21 | 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

KARYN WOOD (601), JENNIFER BATTEN (672)

## 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): On-site April 29, May 3, 4, 5, 6, 7, 10, 11, 2021 and off-site on May 12, 2021.**

**The following intakes and follow-up inspection were completed in this Complaint Report Inspection:**

**A log related to infection control practices.**

**A log related to multiple care concerns and housekeeping.**

**A follow up to Compliance Order (CO) #002 related to O. Reg. 79/10, s. 229 (4) issued in inspection #2021_643111_0001.**

**During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Cares (ADOCs), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeepers (HSK), Dietary Manager (DM), Environmental Service Manager (ESM), residents and their Substitute Decision Maker (SDM).**

**The inspector also reviewed resident health care records, policies, observed the delivery of resident care and services, including staff to resident interactions, and infection control practices in the home.**

**The following Inspection Protocols were used during this inspection:**
**Infection Prevention and Control**
**Medication**
**Nutrition and Hydration**
**Personal Support Services**
**Safe and Secure Home**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 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: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that proper technique including safe positioning was used to assist resident #020, #021, and #022.

Resident #020, #021, and #022 were observed seated in an unsafe position while receiving staff assistance to eat their meals. The PSW acknowledged the residents were not in a safe position for eating and drinking purposes. Record review of each of the resident's current written plan of care indicated they were each at risk when not seated safely. During separate interviews, two PSWs, an RPN and ADOC #101 indicated the expectation in the home was for all residents to be seated in a safe position during food and fluid intake. By not ensuring all residents were seated in a safe position for eating and/or drinking purposes, the residents were placed at an increased risk for a negative outcome.

Sources: Observation of meal services, residents #020, #021, and #022's current written plan of care and interviews with two PSWs, an RPN and an ADOC. [s. 73. (1) 10.]

***Additional Required Actions:***

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

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**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. (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 :**

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program (IPAC) related to isolation signage, care caddies not being fully stocked with Personal Protective Equipment (PPE), staff adherence to safely don and doff PPE, and hand hygiene (HH).

Inspector #111 conducted inspection #2021_643111_0001 at Golden Plough Lodge Nursing Home. On March 1, 2021, Inspector #111 issued non-compliance with O. Reg 79/10, s. 229(4) and CO #002 was issued with a compliance date of March 5, 2021. CO #002 directed the home to ensure signage was posted according to Public Health (PH) guidelines, care caddies were to be fully stocked with PPE, staff adherence to safely don and doff PPE. In addition, the home was to conduct daily audits on all three shifts to evaluate staff adherence to proper donning and doffing of PPE and HH.

The Follow up IPAC inspection was conducted by Inspector #601 and Inspector #672 and several IPAC concerns were identified in the home during the inspection.

Observation of the isolation signage for residents identified that staff failed to ensure that appropriate signage for additional precautions was posted. The ADOC acknowledged the isolation signage for the residents did not reflect the additional precautions for PPE in place.

Observations of isolation rooms identified on multiple occasions the PPE caddies were missing supplies including masks, disinfectant wipes and gowns. There were isolation rooms that did not have a waste receptacle upon exiting the room. The RN indicated registered staff have access to PPE and staff will notify them when supplies need to be replaced. The ADOC indicated it was the night shifts responsibility to ensure the PPE caddies were fully stocked.

Resident #017’s signage indicated the resident required droplet and contact precautions. PSW #122 did not perform hand hygiene prior to donning PPE. When exiting the resident’s room, the PSW removed their gown and gloves at the same time. The PSW indicated they should have performed hand hygiene prior to entering the resident’s room and they should not have removed the gown and gloves at the same time.

PSW #121 was observed doffing their PPE when exiting resident #013’s room that required contact and droplet precautions. The PSW did not discard their surgical

procedure mask or disinfect their face shield.

Resident #025's signage indicated the resident required droplet and contact precautions. PSW #109 was observed assisting the resident with their meal and they had not donned gloves and their gown was not covering their uniform. When exiting the room, the PSW did not discard their surgical procedure mask or disinfect their face shield.

Resident #028's signage indicated the resident required droplet and contact precautions. RPN #119 was observed taking the resident's temperature and they did not have a gown or gloves on while within two meters of the resident. The RPN did not discard their surgical procedure mask or disinfect their face shield when exiting the resident's room. The RPN acknowledged they should have donned PPE when they entered the resident's room.

Staff indicated they were not aware of the requirement to discard their surgical procedure mask or disinfect their face shield when exiting a resident's room that was on droplet and contact precautions. ADOC #101 indicated that all staff had received education on how to properly don and doff PPE. ADOC #101 also indicated an auditing process was in place for evaluating staff compliance with donning and doffing PPE. Public Health Ontario (PHO) - Universal Mask Use in Health Care Settings and Retirement Homes directed for staff to discard their surgical procedure mask and eye protection when leaving a resident's room that was on droplet and contact precautions when direct care was provided within two meters of a resident.

On Multiple occasions staff were observed to not assist residents with HH before after meals. Staff did not always perform HH before and after providing resident direct care or before administering medication. Staff confirmed they had received education and residents should receive assistance with HH before and after meals, and staff should perform HH before and after providing resident direct care or before and after administering medication. ADOC #101 indicated that all staff received education on "Just Clean Your Hands - Your 4 Moments for Hand Hygiene" program. ADOC #101 also indicated an auditing process was in place for evaluating staff compliance with HH. Review of the Just Clean Your Hands Program – Your 4 moments for Hand Hygiene required staff to assist residents to perform HH before and after meals and snack. Staff were also required to complete hand hygiene before initial resident and after resident environment contact.

Inspector #601 reviewed the donning and doffing of PPE and HH audits completed. The

Registered Nurses (RNs) completed several audits of staff donning and doffing PPE. The audits completed indicated that 18% of staff improperly donned their PPE and 80% of staff improperly doffed their PPE. Interviews with RNs identified they had not received education on how staff should be donning and doffing PPE, while wearing the universal surgical procedure mask and face shields. It was identified that some of the RNs and PSWs were not aware that they were required to discard their surgical procedure mask and doff or disinfect their face shields when exiting a resident's room that required droplet and contact precautions. The RNs also completed several audits of staff preforming HH. The HH audits completed indicated several staff did not complete the required HH. ADOC #101 indicated the RNs completed the donning and doffing of PPE and Hand Hygiene (HH) audits and on the spot education. ADOC #101 confirmed a record of the staff names audited was not maintained and they had no record of the staff that were not following the IPAC procedures for donning and doffing PPE and HH. ADOC #101 further indicated they had not analyzed the results of the PPE and HH audits.

Multiple water bottles were observed at the nursing station and on the handrails in hallway(s) throughout the inspection. The RN verified the water bottles belonged to staff and was not sure of the home's policy regarding beverages being consumed in resident common areas. An RPN was observed to have a water bottle on top of the medication cart, they removed their mask and face shield to take a drink, no hand hygiene was performed. ADOC #101 indicated water was permitted and drinks were not to be kept on the medication cart.

The long-term care home's IPAC program included the requirement for staff to wear a gown, gloves, eye protection and a mask when providing direct care to a resident identified as requiring contact and droplet isolation precautions.

The residents were at actual risk for transmission of infection when staff failed to ensure that appropriate signage was posted, care caddies were not fully stocked with PPE, staff did not properly don and doff PPE, nor did staff consistently perform HH when performing direct care and offer residents HH before and after meals.

Sources: Observation of isolation signage throughout the home, staff IPAC practices, review of resident #013, #015, #016, #017, #018, #025, #026, #027, #028's progress notes, Best Practices for Hand Hygiene in all Health Care Settings, Public Health Ontario (PHO) - Universal Mask Use in Health Care Settings and Retirement Homes, interviews with three PSWs, an RPN , two RNs, HSK, both ADOCs and the DOC. [s. 229. (4)]

***Additional Required Actions:***

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

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**WN #3: 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 :**

1. The licensee has failed to ensure that the home was a safe environment related to the failure to maintain infection prevention and control measures specified in Directive #3 regarding maintaining two metres distance from others while not wearing a mask.

Inspector #601 and Inspector #672 observed multiple residents sitting in common areas and they were not two meters distanced from each other, and they were not wearing a surgical mask.

The Chief Medical Officer of Health (CMOH) implemented Directive #3 which has been issued to long-term care homes and sets out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak of COVID-19 in long-term care homes. The version of Directive #3, all staff and visitors must always comply with universal masking and must wear a medical mask for the entire duration of their shift/visit. Staff are required to comply with universal masking at all times, even when they are not delivering direct patient care, including in administrative areas. During their breaks, to prevent staff-to-staff transmission of COVID-19, staff must remain two metres away from others at all times and be physically distanced before removing their medical mask for eating and drinking. Masks must not be removed when staff are in contact with residents and/or in designated resident areas. As per Directive #3, LTCHs must have a plan for and use related to staff and resident cohorting, to the extent possible, staff and resident cohorting as part of their approach to preparedness, as well as to prevent the spread of COVID-19 once identified in the LTCH.

Assistant Director of Care (ADOC) indicated the expectation is all staff will comply with universal masking at all times in accordance with Directive #3.

The lack of adherence to Directive #3 related to universal masking and physical distancing of residents presented an actual risk of exposing the residents to COVID-19, if the home were to experience an outbreak.

Sources: Directive #3, staff and resident observations throughout the home and interview with the ADOC. [s. 5.]

***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 shall ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.***

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**WN #4: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff collaborated with the Registered Dietitian (RD) when the resident was experiencing nutritional issues.

A resident received tray service and the PSW was observed to remove the resident's full meal. The resident told the PSW that they didn't want to eat. The PSW indicated the resident required supervision with meals and had not been eating. Review of the resident’s progress notes, and nutritional intake identified the resident had several meals with decreased or no nutritional intake and the resident was experiencing a specified symptom.

The Nurse Practitioner (NP) documented the resident was experiencing specified symptoms, at times during or after meals or medication administration. The NP documented and ordered for the RD to be consulted. The RD completed the resident’s routine dietary referral and noted the resident would sometimes have the specified symptom following a meal. The RD confirmed staff had not collaborated with them regarding the resident’s decreased nutritional intake nor had they been informed of the frequency of the resident’s specified symptom. The RD indicated the resident’s dietary referral should have included the details that the resident was leaving 25% or more of their food over a seven-day period or that the specified symptom had lasted more than 48 hours. The RD indicated further intervention was required to meet the resident’s nutritional needs and the resident would be prescribed a treatment.

There was actual risk for the resident to experience nutritional deficits when staff did not collaborate with the RD regarding the nutritional issues.

Sources: Golden Plough Lodge Criteria for Referral to the Dietitian policy, a resident progress notes, Point of Care Nutritional Intake, Dietary referral and interviews with a PSW and the RD. [s. 6. (4) (a)]

***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 staff and others involved in the different aspects of care of the resident collaborate with each other, to be implemented voluntarily.***

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**WN #5: 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 has failed to ensure that an internal medication administration policy was complied with.

According to LTCHA, 2007. 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.

A complaint was received by the Director related to medication practices and several areas of care concern. During an interview, the complainant indicated there were occasions when the resident had outside appointments, which required staff to send medications along. The complainant indicated staff sent a liquid medication in a urine collection cup and an empty juice bottle. The complainant indicated it made them and the resident feel humiliated to have to drink medication from a urine collection bottle and

concerned regarding the cleanliness of the empty juice bottle. The complainant further indicated when the staff provided the medication(s), they did not provide any education or review of medication administration practices; they were not required to review or sign any documentation; the bottles were not labelled with any information regarding the names or dosages of the medication(s) and staff did not follow up with them upon return to the home regarding if/when the medication(s) were administered to the resident.

Review of the internal medication management policy entitled “Leave of Absence (LOA) Medication”; policy indicated the following:

- Labelling on LOA medications must include: name of home; name of resident; name of prescriber; name of medication, strength, quantity and complete directions for use; and the initials of the individual preparing the medications for the LOA.

- Communication with the pharmacy must occur as soon as the LOA is confirmed. Staff complete and fax Form 10.4 Resident Status to pharmacy. The packaging preference (e.g. blister card, vials, childproof vials) is indicated on the form.

- Nursing staff provide resident/POA education on medication administration/handling. Document education and quantity in notes.

- Upon return, staff check the medication packaging for any unused medication. If discrepancies exist with the returned medication, the inconsistency is documented in progress notes and communicated to pharmacy.

During an interview, the RPN indicated there was not a set practice in the home for when residents went on LOA with liquid medications and was aware that staff usually administered liquid medications in unlabeled urine collection cups. The RPN further indicated staff were aware of the required documentation to be completed when sending medication(s) for an LOA, but acknowledged that the paperwork was rarely completed.

During an interview, ADOC #101 verified they had instructed staff to utilize urine collection cups to send liquid medications with residents for LOAs, as the cups were considered to be sterile, but did not reflect on the optics of how it may look and/or feel to the resident/POA. ADOC #101 indicated there was an internal policy related to when a resident left the home for a LOA with medications and that staff could reach out to the pharmacy for assistance with packaging for liquid medications. ADOC #101 further indicated staff were expected to complete education with the resident/POA on medication

administration practices such as the name and dosage of the medication(s), how and when to administer the medication(s) and any possible side effects. Upon the resident's return to the home, staff were expected to check with the resident/POA that the medication(s) were administered according to the directions for use listed by the prescriber, if there was any medication left over and document the conversation and outcome.

By not ensuring the internal policy entitled "Leave of Absence (LOA) Medication" was followed, residents were placed at risk of not having their medications administered according to the directions; medications could have become contaminated and residents/POAs were placed at risk of experiencing feelings of confusion and embarrassment when having to administer medications from items such as urine collection cups.

Sources: Internal policy entitled "Leave of Absence (LOA) Medication" policy; interviews with complainant, RPN and ADOC #101. [s. 8. (1) (b)]

***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 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, (b) is complied with, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids**

**Specifically failed to comply with the following:**

**s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,**
**(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).**
**(b) cleaned as required. O. Reg. 79/10, s. 37 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that personal items were labelled.

A complaint was received by the Director related to concerns regarding the cleanliness of resident bathrooms and IPAC practices in the home.

Observations conducted revealed there were multiple personal items in the shared resident bathrooms, such as used rolls of deodorant, toothbrushes and hairbrushes, which were not labelled with the resident's name. Several observations in the shared resident bathrooms on two of the resident home areas indicated there were unlabelled personal items being used for the residents, but staff members could not indicate who the items belonged to.
.
During an interview, ADOC #101 verified the expectation in the home was for all personal items to be labelled with the resident’s name. By not ensuring all personal items were labelled, residents were placed at risk of using another resident’s personal item, which could be unsanitary.

Sources: Observations, interviews with PSWs and ADOC #101. [s. 37. (1) (a)]

***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 ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, (a) labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that drugs were stored in an area or medication cart that was used exclusively for drugs and drug-related supplies and was kept secured and locked.

Observations conducted revealed that the home had been keeping medicated treatment creams in a resident's bedroom. Inspector observed a PSW carrying a basin with several bottles of medicated treatment creams within. The RPN verified medicated treatment creams had been kept in the resident's bedroom but were not supposed to have been stored in the resident's bedroom, therefore removed the bottles from the basin and returned them to the medication cart.

The RPN and ADOC #101 indicated medicated treatment creams were always supposed to be stored in the locked medication rooms when not being used. By not ensuring medicated treatment creams were stored in an area or medication cart that was kept secured and locked, residents were placed at risk of applying the treatment creams independently and/or the medicated creams not being applied according to the directions for use specified by the prescriber.

Sources: Observation, interviews with an RPN and ADOC #101. [s. 129. (1) (a)]

***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 ensure that, (a) drugs are stored in an area or a medication cart, (i) that is used exclusively for drugs and drug-related supplies, (ii) that is secure and locked, to be implemented voluntarily.***

**Issued on this 14th day of June, 2021**

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| **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

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|---|---|
| **Name of Inspector (ID #) / Nom de l’inspecteur (No) :** | KARYN WOOD (601), JENNIFER BATTEN (672) |
| **Inspection No. / No de l’inspection :** | 2021_885601_0010 |
| **Log No. / No de registre :** | 026060-20, 001449-21, 004557-21 |
| **Type of Inspection / Genre d’inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Jun 9, 2021 |
| **Licensee / Titulaire de permis :** | The Corporation of the County of Northumberland<br>983 Burnham Street, Cobourg, ON, K9A-5J6 |
| **LTC Home / Foyer de SLD :** | Golden Plough Lodge<br>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**

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

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**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. 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:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

**Order / Ordre :**

The licensee must be compliant with section s. 73. (1) 10 of O. Reg. 79/10.

Specifically, the licensee must:

1. Conduct daily audits of meal services for a period of two weeks to ensure safe positioning of residents during meals. If unsafe positioning is noted, provide immediate redirection and reeducation. Keep a documented record of the audits completed.

**Grounds / Motifs :**

1. The licensee has failed to ensure that proper technique including safe positioning was used to assist resident #020, #021, and #022.

Resident #020, #021, and #022 were observed seated in an unsafe position while receiving staff assistance to eat their meals. The PSW acknowledged the residents were not in a safe position for eating and drinking purposes. Record review of each of the resident's current written plan of care indicated they were each at risk when not seated safely. During separate interviews, two PSWs, an RPN and ADOC #101 indicated the expectation in the home was for all residents to be seated in a safe position during food and fluid intake. By not ensuring all residents were seated in a safe position for eating and/or drinking purposes, the residents were placed at an increased risk for a negative outcome.

Sources: Observation of meal services, residents #020, #021, and #022's current written plan of care and interviews with two PSWs, an RPN and an ADOC. [s. 73. (1) 10.]

An order was made by taking the following factors into account:

Severity: There was actual risk of harm, as residents were assisted with food and fluid intake while in unsafe positions. This practice could lead to a negative outcome for the residents.

Scope: The scope of this non-compliance was widespread, as more than three residents were affected.

Compliance History: One or more areas of non-compliance were issued to the home under different sub-sections of the legislation within the previous 36 months.
(672)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jul 08, 2021

**Order # / No d'ordre :** 002

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

**Linked to Existing Order / Lien vers ordre existant:** 2021_643111_0001, CO #002;

**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) of the LTCHA.

Specifically, the Licensee must:

-Ensure appropriate signage is in place at the entrance to residents' rooms where staff are required to utilize additional personal protective equipment (PPE).

-Ensure care caddies are always fully stocked and contain the necessary PPE so that supplies are always available to staff when entering and exiting a resident's room that requires additional precautions.

-Audit staff compliance to the proper technique for donning and doffing of PPE and Hand Hygiene (HH) daily every shift until all staff have been audited and can demonstrate proper technique consistently. Keep a record of all staff that were audited. Analyze the results of the audits and provide further education to any staff who did not adhere to the proper technique for donning and doffing of PPE and HH. Keep a record of the staff that required further education and continue audits for the staff identified until the staff member has achieved compliance.

**Grounds / Motifs :**

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program (IPAC) related to isolation signage, care caddies not being fully stocked with Personal Protective Equipment (PPE), staff adherence to safely don and doff PPE, and hand

hygiene (HH).

Inspector #111 conducted inspection #2021_643111_0001 at Golden Plough Lodge Nursing Home. On March 1, 2021, Inspector #111 issued non-compliance with O. Reg 79/10, s. 229(4) and CO #002 was issued with a compliance date of March 5, 2021. CO #002 directed the home to ensure signage was posted according to Public Health (PH) guidelines, care caddies were to be fully stocked with PPE, staff adherence to safely don and doff PPE. In addition, the home was to conduct daily audits on all three shifts to evaluate staff adherence to proper donning and doffing of PPE and HH.

The Follow up IPAC inspection was conducted by Inspector #601 and Inspector #672 and several IPAC concerns were identified in the home during the inspection.

Observation of the isolation signage for residents identified that staff failed to ensure that appropriate signage for additional precautions was posted. The ADOC acknowledged the isolation signage for the residents did not reflect the additional precautions for PPE in place.

Observations of isolation rooms identified on multiple occasions the PPE caddies were missing supplies including masks, disinfectant wipes and gowns. There were isolation rooms that did not have a waste receptacle upon exiting the room. The RN indicated registered staff have access to PPE and staff will notify them when supplies need to be replaced. The ADOC indicated it was the night shifts responsibility to ensure the PPE caddies were fully stocked.

Resident #017's signage indicated the resident required droplet and contact precautions. PSW #122 did not perform hand hygiene prior to donning PPE. When exiting the resident's room, the PSW removed their gown and gloves at the same time. The PSW indicated they should have performed hand hygiene prior to entering the resident's room and they should not have removed the gown and gloves at the same time.

PSW #121 was observed doffing their PPE when exiting resident #013's room that required contact and droplet precautions. The PSW did not discard their surgical procedure mask or disinfect their face shield.

Resident #025's signage indicated the resident required droplet and contact precautions. PSW #109 was observed assisting the resident with their meal and they had not donned gloves and their gown was not covering their uniform. When exiting the room, the PSW did not discard their surgical procedure mask or disinfect their face shield.

Resident #028's signage indicated the resident required droplet and contact precautions. RPN #119 was observed taking the resident's temperature and they did not have a gown or gloves on while within two meters of the resident. The RPN did not discard their surgical procedure mask or disinfect their face shield when exiting the resident's room. The RPN acknowledged they should have donned PPE when they entered the resident's room.

Staff indicated they were not aware of the requirement to discard their surgical procedure mask or disinfect their face shield when exiting a resident's room that was on droplet and contact precautions. ADOC #101 indicated that all staff had received education on how to properly don and doff PPE. ADOC #101 also indicated an auditing process was in place for evaluating staff compliance with donning and doffing PPE. Public Health Ontario (PHO) - Universal Mask Use in Health Care Settings and Retirement Homes directed for staff to discard their surgical procedure mask and eye protection when leaving a resident's room that was on droplet and contact precautions when direct care was provided within two meters of a resident.

On Multiple occasions staff were observed to not assist residents with HH before after meals. Staff did not always perform HH before and after providing resident direct care or before administering medication. Staff confirmed they had received education and residents should receive assistance with HH before and after meals, and staff should perform HH before and after providing resident direct care or before and after administering medication. ADOC #101 indicated that all staff received education on "Just Clean Your Hands - Your 4 Moments for Hand Hygiene" program. ADOC #101 also indicated an auditing process was in place for evaluating staff compliance with HH. Review of the Just Clean Your Hands Program – Your 4 moments for Hand Hygiene required staff to assist residents to perform HH before and after meals and snack. Staff were also required to complete hand hygiene before initial resident and after resident

environment contact.

Inspector #601 reviewed the donning and doffing of PPE and HH audits completed. The Registered Nurses (RNs) completed several audits of staff donning and doffing PPE. The audits completed indicated that 18% of staff improperly donned their PPE and 80% of staff improperly doffed their PPE. Interviews with RNs identified they had not received education on how staff should be donning and doffing PPE, while wearing the universal surgical procedure mask and face shields. It was identified that some of the RNs and PSWs were not aware that they were required to discard their surgical procedure mask and doff or disinfect their face shields when exiting a resident's room that required droplet and contact precautions. The RNs also completed several audits of staff preforming HH. The HH audits completed indicated several staff did not complete the required HH. ADOC #101 indicated the RNs completed the donning and doffing of PPE and Hand Hygiene (HH) audits and on the spot education. ADOC #101 confirmed a record of the staff names audited was not maintained and they had no record of the staff that were not following the IPAC procedures for donning and doffing PPE and HH. ADOC #101 further indicated they had not analyzed the results of the PPE and HH audits.

Multiple water bottles were observed at the nursing station and on the handrails in hallway(s) throughout the inspection. The RN verified the water bottles belonged to staff and was not sure of the home's policy regarding beverages being consumed in resident common areas. An RPN was observed to have a water bottle on top of the medication cart, they removed their mask and face shield to take a drink, no hand hygiene was performed. ADOC #101 indicated water was permitted and drinks were not to be kept on the medication cart.

The long-term care home's IPAC program included the requirement for staff to wear a gown, gloves, eye protection and a mask when providing direct care to a resident identified as requiring contact and droplet isolation precautions.

The residents were at actual risk for transmission of infection when staff failed to ensure that appropriate signage was posted, care caddies were not fully stocked with PPE, staff did not properly don and doff PPE, nor did staff consistently perform HH when performing direct care and offer residents HH before and after

meals.

Sources: Observation of isolation signage throughout the home, staff IPAC practices, review of resident #013, #015, #016, #017, #018, #025, #026, #027, #028's progress notes, Best Practices for Hand Hygiene in all Health Care Settings, Public Health Ontario (PHO) - Universal Mask Use in Health Care Settings and Retirement Homes, interviews with three PSWs, an RPN , two RNs, HSK, both ADOCs and the DOC. [s. 229. (4)]

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. Specifically, signage for additional precautions was not always in place or specific to the resident's additional precautions required, resident care caddies were not always fully stocked with the required PPE, staff were not always adhering to the proper sequence of donning and doffing of PPE, and hand hygiene practices.

Scope: The scope of this non-compliance was widespread because the IPAC, PPE, and hand hygiene deficiencies noted affect all residents in the Home.

Compliance History: the home has had non-compliance to different subsection in the past 36 months as follows:
-Compliance Order #002 was issued to O. Reg. 79/10, s.229(4) on March 1, 2021.
-a Voluntary Plan of Correction (VPC) was issued to O.Reg.79/10, s.229(3) on December 3, 2020 and March 1, 2021.
-a VPC was issued to O. Reg. 79/10, s. 229(5) on January 27, 2020.
-Multiple written notifications (WNs) and voluntary plans of correction (VPCs) were issued to the Licensee for its non-compliance with different sub-sections/requirements under the LTCHA in the past 36 months of the inspection.

(601)

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 :** Jul 08, 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 9th day of June, 2021**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Karyn Wood

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