Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central East District
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Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: October 13, 2023

Inspection Number: 2023-1553-0004

Inspection Type:
Critical Incident
Follow up

Licensee: The Corporation of the County of Northumberland

Long Term Care Home and City: Golden Plough Lodge, Cobourg

Lead Inspector	**Inspector Digital Signature**
Julie Dunn (706026)	Julie Dunn Digitally signed by Julie Dunn Date: 2023.10.16 15:48:32 -04'00'

Additional Inspector(s)
Reethamol Sebastian (741747)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 20 - 22, and 25 - 28, 2023 and October 3, 2023.

The following intake(s) were inspected:

- Intake #00090711 - Follow-up #: 2 - CO #001 / 2022-1553-0002, O. Reg. 246/22 s. 102 (2) (b), Infection Prevention and Control (IPAC) standard 9.1 (e) and standard 10.1, CDD April 24, 2023, RIF $500.
- Intake #00090713 - Follow-up #: 3 - CO #004 / 2022-1553-0001, O. Reg 246/22 s. 102 (2) (b) IPAC standard 9.1 (e), CDD August 31, 2022.
- Intake #00090712 - Follow-up #: 3 - CO #005 / 2022-1553-0001, O. Reg 246/22 s. 102 (2) (b) IPAC standard 9.1 (f), CDD August 31, 2022.
- Intakes #00089271, #00089809, and #00090740 related to medication administration.
- Intakes #00091656 and #00093349 related to allegations of staff to resident abuse/neglect.
- Intake: #00095217 related to falls prevention and management.

The following **Inspection Protocols** were used during this inspection:

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Compliance Order #001 from Inspection #2022-1553-0002, O. Reg. 246/22 s. 102 (2) (b), Infection Prevention and Control (IPAC) standard 9.1 (e) and standard 10.1, inspected by Julie Dunn (706026).

Compliance Order #004 from Inspection #2022-1553-0001, O. Reg 246/22 s. 102 (2) (b) IPAC standard 9.1 (e), inspected by Julie Dunn (706026).

Compliance Order #005 from Inspection #2022-1553-0001, O. Reg 246/22 s. 102 (2) (b) IPAC standard 9.1 (f), inspected by Julie Dunn (706026).

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee failed to ensure that it was immediately reported to the Director when a person had reasonable grounds to suspect that incompetent care of a resident occurred that resulted in a risk of harm to the resident.

Rationale and Summary
A critical incident report was submitted to the Director which indicated that the wrong medication was administered to a resident seven weeks prior to the report submission.

A complaint letter received by the long-term care home from the family of the resident indicated that a registered practical nurse (RPN) administered the wrong medication to the resident.

A registered nurse (RN) indicated that they were the charge nurse on duty when a registered practical nurse (RPN) immediately reported that they accidentally gave the resident medication that was intended for another resident. The RPN and RN indicated that the management on call, the physician and the resident's family were notified right away. The RPN and RN indicated there was a risk of the resident having an adverse reaction when the wrong medication was administered.

The Assistant Director of Care (ADOC) confirmed the wrong medication was administered to the resident. The ADOC submitted the critical incident report and acknowledged there was confusion with the reporting of the medication administration incident.

Failing to immediately report when a person had reasonable grounds to suspect that incompetent care of a resident occurred that resulted in a risk of harm to the resident, creates risk of ongoing incompetent care of the resident and other residents.

Sources: Critical incident report, long-term care (LTC) home's internal investigation documents, interviews with staff.
[706026]

WRITTEN NOTIFICATION: Bedtime and rest routines

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 45

The licensee has failed to ensure that a resident's desired bedtime and rest routines were supported and individualized to promote comfort, rest, and sleep.

Rationale and Summary

A critical incident report was submitted to the Director related to a resident's care issues. The resident's plan of care identified a specific preferred bedtime. On a specific date, the resident returned to the LTC home late from an outing and a personal support worker (PSW) approached resident and offered to put them in bed. The resident refused to go to bed as they had not taken their medication. The PSW informed the resident that if they did not go to bed now then they would not be going to bed until two hours later. The resident requested for the PSW to apologize for being rude. The resident went to bed

at a time requested by the resident. The next day the resident complained to the ADOC regarding the incident.

The ADOC acknowledged that the PSW did not support the resident's desired bedtime and rest routines when they tried to forcibly transfer the resident to bed early.

The PSW's failure to follow the resident's desired bedtime and rest routines resulted in the resident feeling disrespected and posed a risk to their comfort, dignity, and sleep.

Sources: Interviews with the resident and staff, the LTC home's internal investigation notes and disciplinary action note, the resident's clinical records.
[741747]

WRITTEN NOTIFICATION: Administration of drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)

1.The licensee failed to ensure that no drug was administered to a resident unless the drug was prescribed for the resident.

Rationale and Summary
A critical incident report was submitted to the Director which indicated that a medication was administered to a resident in error and this resident had no doctor's order for the medication.

A progress note by an RPN documented that they administered the medication to the resident in error, noted the RN was notified immediately, and noted an assessment of the resident. Direction provided by the physician was to closely monitor the resident for 24 hours. The RN documented the medication error, and noted that the resident's family, the physician, and management were notified.

In an interview, the RPN indicated they knew the residents on the unit well and they were aware that that the medication was considered a high alert medication. The RPN indicated that it was a busy night, they got distracted and mixed up. The RPN noted that they realized the error immediately and called the RN on duty, then the doctor, the resident's family and the ADOC were all notified. The RPN specified that there was no adverse effect.

The RN on duty indicated that the RPN reported they administered the medication to the resident by

mistake and the RPN explained that they were distracted. The RN noted the medication could impact the resident for a period of 12 hours. The RN asked the RPN to monitor the resident. The RN noted that there was no adverse effect. The RN noted the expectation is to do checks before administering a medication for the right patient, the right medication, the right dose.

The ADOC confirmed that the RPN administered the medication to the resident, who did not have the medication prescribed, in error. The ADOC indicated that the expectations should be to check to ensure the right resident, and that medication administration protocols should be followed. The ADOC indicated that there was corrective action and RN supervision for the RPN and education for all registered staff.

Failing to ensure that no drug was administered to a resident unless the drug was prescribed for the resident, put the resident at risk of adverse reaction.

Sources: Clinical records, LTC home's internal investigative documents, interviews with staff. [706026]

2.The licensee failed to ensure that no drug was administered to a resident unless the drug was prescribed for the resident.

Rationale and Summary
A critical incident report was submitted to the Director indicating that a complaint letter from the family of a resident was received by the LTC home. The complaint letter indicated that a medication was administered to the resident in error.

An RPN indicated that they gave a resident the wrong medication in error, that it was intended for another resident. The RPN noted that they realized the error immediately and called the RN Charge Nurse on duty. The RPN indicated they knew the residents on the unit well and were aware that the medication was high alert, and they did not slow down to check. The RPN indicated that notifications were provided to management, the physician, and to the resident's family. The physician ordered extra assessments and advised to monitor for any adverse effects like an allergic reaction.

The RN indicated that the RPN reported they got distracted and accidentally gave the resident the medication. The resident was scheduled to receive a different medication. The RN called the physician to get direction and informed the resident's family. The RN noted that the expectation prior to administering medication is to do a check, to keep doing it twice or three times.

A progress note entered by the RN noted that the RPN informed the RN that they accidentally gave the

resident the wrong medication, and the RN phoned the doctor who instructed to monitor resident.

The ADOC confirmed the wrong medication was administered to the resident and pharmacy was asked and provided refresher education to all registered staff. The ADOC noted the expectations should be to check, to ensure the right resident and to follow medication administration protocols.

Failing to ensure that no drug was administered to the resident unless the drug was prescribed for the resident, put the resident at risk of adverse reaction.

Sources: Clinical records, LTC home internal investigation documents, interviews with staff. [706026]

NOTICE OF RE-INSPECTION FEE

Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021,the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.

A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.

Follow-up #: 2 - CO #001 / 2022-1553-0002, O. Reg. 246/22 s. 102 (2) (b), Infection Prevention and Control (IPAC) standard 9.1 (e) and standard 10.1, CDD April 24, 2023.

Follow-up #: 3 - CO #005 / 2022-1553-0001, O. Reg 246/22 s. 102 (2) (b) IPAC standard 9.1 (f), CDD August 31, 2022.

Follow-up #: 3 - CO #004 / 2022-1553-0001, O. Reg 246/22 s. 102 (2) (b) IPAC standard 9.1 (e), CDD August 31, 2022.

Licensees must not pay a Re-Inspection Fee from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the Re-Inspection Fee.