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

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Original Public Report

Report Issue Date: July 5, 2024	
Inspection Number: 2024-1553-0002	
Inspection Type: Critical Incident	
Licensee: The Corporation of the County of Northumberland	
Long Term Care Home and City: Golden Plough Lodge, Cobourg	
Lead Inspector Julie Mercer (000737)	**Inspector Digital Signature**
Additional Inspector(s) Sarah Gillis (623)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 3-7, 2024.

The following intake(s) were inspected:
A Critical Incident related to a resident fall that resulted in injury and a significant change in health status.

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

Housekeeping, Laundry, and Maintenance Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: HOME TO BE SAFE, SECURE ENVIRONMENT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 5

Home to be safe, secure environment

s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee has failed to ensure a safe and secure environment was provided to all residents.

Rationale and Summary

A Critical Incident Report (CIR) was received by the Director related to a resident fall.

Observation during the inspection, Inspector observed that a home area tub room door was left open, and unsupervised with multiple cleaning chemicals easily accessible to residents.

Inspector observed that a home area's tub room was unsupervised and contained one bottle of Oxivir Plus and two bottles of Diversey Bathroom Cleaner and Scale Remover.

A Registered Practical Nurse (RPN) confirmed that all tub room doors were to be closed and locked, at all times, for resident safety.

Failure to ensure that a home area's tub room door was kept closed and locked, with chemicals left accessible and unsupervised, has placed residents at risk for potential injury and/or accidental poisoning.

Sources: Inspector observation, and an interview with staff. [000737]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident.

The licensee failed to ensure that a resident's written plan of care set out clear directions to staff related to a resident's fall's prevention interventions, Personal Assistance Services Device (PASD) and/or restraint.

Rationale and Summary

A CIR was received by the Director related to a resident fall that resulted in injury and a significant change in health status.

Review of a resident's plan of care did not indicate clear direction to staff for a resident's use of falls prevention interventions, PASD and/or restraint.

A PSW confirmed that they were aware of a resident's past falls interventions and were unaware of a resident's current fall's interventions, which included monitoring of a resident's when using a PASD and/or restraint.

Observation during inspection, Inspector observed that a resident's falls prevention interventions, indicated in the plan of care, were inconsistent with a resident's beside fall's logos and Point of Care (POC) tasks for PSW documentation.

Observation during inspection, Inspector observed that a resident did not have one of their falls interventions in place as indicated in the plan of care.

A Physiotherapist (PT) confirmed that a resident using a PASD and/or restraint, were to be repositioned every hour as indicated in the plan of care.

Review of a resident's plan of care indicated fall's prevention interventions were in place and not being followed by staff.

Failure to ensure that a resident's written plan of care set out clear directions to staff on the use of falls prevention interventions, PASD and/or restraint has placed a resident at increased risk for future falls and potential injury.

Sources: A CIR, the home's Physical Restraints and Restraint Monitoring Policies, a resident's electronic health records, Inspector observations, and interviews with staff. [000737]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of a resident's care, set out in the plan was documented for the use of a PASD and/or restraint.

Rationale and Summary

A CIR was received by the Director related to a resident fall that resulted in injury and a significant change in health status.

A resident's progress notes, at a specific date/time, indicated that a resident was transferred into a PASD and/or restraint.

A resident was assessed by a PT who implemented the use of a PASD and/or restraint for safety. A PSW and PT, both confirmed that a resident was unable to remove themselves when using a PASD and/or restraint.

Review of a resident's plan of care did not indicate a Focus for the use of a PASD and/or restraint.

A Director of Care (DOC) confirmed that a resident's plan of care did not indicate the use of a PASD and/or restraint and should have.

Failure to ensure that the provision of a resident's care, set out in the plan of care, was documented related to the use of a PASD and/or restraint has placed a resident's safety at risk.

Sources: A CIR, the home's Physical Restraints Policy, a resident's electronic health records, Inspector observations, and interviews with staff. [000737]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (9) 2.

Plan of care

s. 6 (9) The licensee shall ensure that the following are documented:

2. The outcomes of the care set out in the plan of care.

The licensee has failed to ensure that the outcomes of a resident's care, set out in the plan of care, related to fall's prevention interventions were documented.

Rationale and Summary

A CIR was received by the Director related to a resident fall that resulted in injury and a significant change in health status.

A resident's plan of care did not indicate all fall's prevention interventions that were currently in place for a resident.

Review of a resident's Point of Care (POC) tasks, did not indicate all current falls prevention interventions that were currently in place for a resident, as directed by the home's "Falls Prevention Devices" Policy.

Review of a resident's POC tasks for falls prevention interventions indicated that PSW documentation was required on every shift.

Review of a resident's POC tasks for fall's prevention interventions, indicated that the required PSW documentation on every shift was missing on numerous dates/times during a specific time frame.

Failure to ensure that the outcomes of a resident's care, set out in the plan of care, were documented related to falls prevention interventions has placed a resident at increased risk for falls and potential injury.

Sources: A CIR, the home's Fall's Prevention Devices Policy, a resident's electronic health records, and Inspector observations. [000737]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary.

The licensee has failed to ensure that when a resident was reassessed, the plan of care was reviewed and revised when the residents care needs changed, in relation to fall's prevention interventions and the use of a PASD and/or restraint.

Rationale and Summary

A CIR was received by the Director related to a resident fall that resulted in injury and a significant change in health status.

A PSW and an RPN, both confirmed a change in a resident's falls prevention interventions.

Review of a resident's plan of care did not indicate all fall's prevention interventions that were currently in place for a resident.

Review of a resident's plan of care did not indicate the use of and monitoring of a resident when using a PASD and/or restraint.

Review of a resident's assessment documentation, conducted on a specific date, did not indicate all fall's prevention interventions that were currently in place. For a resident. Additionally, a resident's assessment documentation did not indicate a change in a resident's health status, and indicated that the plan of care was reviewed, current, and did not require updating.

Review of a resident's assessment documentation, conducted on a specific date, indicated that the plan of care was updated with the use of a PASD and/or restraint.

A DOC confirmed that a resident's plan of care was not updated when the resident's care needs changed and should have.

A PT confirmed that a resident was to be repositioned every hour when using a PASD and/or restraint, as indicated in the plan of care. A PT confirmed that a resident's plan of care was not updated when a resident's care needs changed.

A PSW confirmed that they were unaware of directions for monitoring of a resident when using a PASD and/or restraint.

A PSW confirmed that a resident's fall's prevention intervention device was discontinued when a resident's care needs changed.

Review of a resident's plan of care indicated that a discontinued fall's prevention intervention device was indicated in the plan of care.

Failure to ensure, when a resident's care needs changed, that the plan of care was reviewed and revised, has placed a resident's safety and well-being at risk.

Sources: A CIR, the home's Physical Restraints and Restraint Monitoring Policies, a resident's electronic health records, Inspector observations, and interviews with staff. [000737]

WRITTEN NOTIFICATION: REQUIREMENTS RELATING TO RESTRAINING BY A PHYSICAL DEVICE

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (2) 3.

Requirements relating to restraining by a physical device
s. 119 (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 35 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.

The licensee has failed to ensure that when a resident was restrained by a PASD and/or restraint, the resident was monitored at least every hour by a member of the Registered Nursing Staff or by another member of staff as authorized by a member of the Registered Nursing Staff for that purpose.

Rationale and Summary

A CIR was received by the Director related to a resident fall that resulted in injury and a significant change in health status.

Review of a resident's plan of care indicated fall's prevention interventions that included the use of a PASD and/or restraint.

An ADOC and DOC, both confirmed that PSWs were responsible to monitor a resident's use of a PASD and/or restraint every hour for safety and document the monitoring in a POC task.

Review of a resident's POC care task indicated that a resident required monitoring every hour.

Review of a resident's POC tasks indicated, on a specific date/time, that the resident's restraint was applied. For the same date, review of a resident's POC tasks confirmed that numerous hourly safety checks were not conducted, and a resident's

progress notes did not indicate a rationale for not conducting hourly safety checks, during a specific time frame.

Review of a resident's POC task, did not indicate who or when a PASD and/or restraint was applied for a resident on numerous dates/times, during a specific time frame. On the same date, a review of a resident's progress notes, did not indicate a rationale for not documenting who or when a PASD and/or restrain was applied on numerous dates/times, during a specific time frame.

Failure to ensure that when a resident was restrained by a PASD and/or restraint, a resident was monitored at least every hour, has placed a resident's well-being and safety at risk.

Sources: A CIR, the home's Physical Restraints and Restraint Monitoring Policies, a resident's electronic health records, and interviews with staff. [000737]

WRITTEN NOTIFICATION: REQUIREMENTS RELATING TO RESTRAINING BY A PHYSICAL DEVICE

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (2) 4.
Requirements relating to restraining by a physical device
s. 119 (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 35 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition themself.)

The licensee has failed to ensure that when a resident was restrained by a PASD and/or restraint, the resident was released from the physical device and

repositioned at least once every two hours.

Rationale and Summary

A CIR was received by the Director related to a resident fall that resulted in injury and a significant change in health status.

Review of a resident's plan of care indicated the use of a PASD and/or restraint as falls prevention interventions.

Review of a resident's plan of care did not indicate a repositioning strategy for the use of a PASD and/or restraint.

A DOC and PT, both confirmed that a resident's plan of care did not indicate a Focus for the use of a PASD and/or restraint and did not provide a repositioning strategy for a resident.

A PT confirmed that a resident was to be repositioned every hour when using a PASD and/or restraint.

A PSW and PT, both confirmed that a resident was unable to remove themselves when using a PASD and/or restraint.

A PSW confirmed that they were unaware of a resident's required repositioning when using a PASD and/or restraint.

Review of a resident's POC task documentation for a specific time frame, indicated the following:

Fourteen instances when a resident required repositioning when using a PASD and/or restraint and was not indicated in PSW's documentation.

Twenty-three instances when PSW documentation indicated a resident response that warranted a resident's repositioning when using a PASD and/or restraint and was not indicated in PSW's documentation.

Five instances when a resident's response was not indicated in PSW's documentation.

Failure to ensure that a resident was released from a PASD and/or restraint and repositioned at least once every two hours has placed a resident's safety and well-being at risk.

Sources: A CIR, the home's Physical Restraints and Restraint Monitoring Policies, a resident's electronic health records, and interviews with staff. [000737]

WRITTEN NOTIFICATION: REQUIREMENTS RELATING TO RESTRAINING BY A PHYSICAL DEVICE

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (7) 4.
Requirements relating to restraining by a physical device
s. 119 (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 35 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
4. Consent.

The licensee has failed to ensure documented consent was obtained related to a resident's use of a PASD and/or restraint.

Rationale and Summary

A CIR was received by the Director related to a resident fall that resulted in injury and a significant change in health status.

A PT confirmed that a resident was assessed post-fall, and implemented the use of a PASD and/or restraint for safety.

A DOC confirmed that prior to the application of a resident's PASD and/or restraint, signed consent was to be obtained on the home's paper PASD/restraint consent form. A DOC confirmed that signed PASD/restraint consent forms were stored in a resident's physical chart located at the nursing station.

Review of a resident's progress notes, for a specific time frame, indicated that a resident's Substitute Decision Maker (SDM) needed to sign a PASD/restraint consent form for the use of a PASD and/or restraint.

During the inspection, Inspector failed to locate a signed consent form by a resident's SDM for the use of a PASD and/or restraint.

Failure to ensure documented consent was obtained for a resident's use of a PASD and/or restraint has placed a resident's safety at risk.

Sources: A CIR, the home's Physical Restraints and Monthly Analysis of Restraints Policies, a resident's electronic and paper health records, Inspector observations, and interviews with staff. [000737]

WRITTEN NOTIFICATION: MINIMIZING OF RESTRAINING

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 122 (a)

Evaluation

s. 122. Every licensee of a long-term care home shall ensure,

(a) that an analysis of the restraining of residents by use of a physical device under section 35 of the Act or pursuant to the common law duty referred to in section 39 of the Act is undertaken on a monthly basis.

The licensee has failed to ensure that an analysis of a resident's use of a PASD and/or restraint was undertaken on a monthly basis.

Rationale and Summary

A CIR was received by the Director related to a resident fall, that resulted in injury and a significant change in their health status.

Review of a resident's plan of care indicated the use of a PASD and/or restraint as a falls prevention intervention.

Review of a resident's plan of care did not indicate a repositioning strategy for the use of a PASD and/or restraint.

A PSW and PT, both confirmed that a resident was unable to remove themselves from the device when using a PASD and/or restraint.

An ADOC and PT, both confirmed that the home's Multidisciplinary Falls Committee (MFC) did not assess or discuss a resident's use of a PASD and/or restraint.

Review of the home's MFC meeting minutes, for a specific time frame, indicated a need to conduct random monthly audits of residents' use of PASD and/or restraint, and an updated list of residents that require them.

An ADOC confirmed that the home was not conducting monthly restraint analysis as directed in the home's "Monthly Analysis of Physical Restraints" Policy.

Failure to ensure that an analysis of a resident's use of a PASD and/or restraint was undertaken on a monthly basis has placed a resident's well-being at risk and did not ensure that the least form of restraint was used.

Sources: A CIR, the home's Monthly Analysis of Restraints Policy, Monthly Analysis of Restraint Use Form, a resident's electronic health records, and interviews with staff. [000737]

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that a resident's nutritional medication was administered to a resident in accordance with the direction for use specified by the prescriber.

Rationale and Summary
A CIR was received by the Director related to a resident fall.

Review of a resident's Electronic Medication Administration Record (EMAR) confirmed the prescriber's direction for a resident's daily administration of a specified medication.

On a specific date/time, Inspector observed a medication cup containing liquid on a resident's bed side table.

Shortly afterwards, an RPN confirmed that they were responsible to administer a resident's medication and that they left the medication cup containing liquid on a resident's bed side table. An RPN confirmed that they had signed a resident's electronic medication administration record that the full dosage was administered, and they were aware that a resident did not consume the full dosage as per prescribers' direction.

Review of a resident's EMAR on same date, confirmed that an RPN signed that a resident received a full dosage of their specific medication.

Additionally, on a specific date/time, Registered Staff documentation did not indicate that that a resident received their specific medication.

Failure to ensure that a resident's medication was administered to a resident in accordance with the direction for use specified by the prescriber has placed a resident at risk.

Sources: A CIR, a resident's electronic health records, Inspector observations and an interview with staff. [000737]