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
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: September 9, 2024	
Inspection Number: 2024-1553-0004	
Inspection Type: Follow up	
Licensee: The Corporation of the County of Northumberland	
Long Term Care Home and City: Golden Plough Lodge, Cobourg	
Lead Inspector The Inspectors	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 20-23, 26-30, 2024.

The following intake(s) were inspected:

- Follow-up #: 1 - CO #006, O. Reg. 246/22, s. 102 (2) (b) related to IPAC - CDD July 30, 2024.
- Follow-up #: 1 - CO #005, O. Reg. 246/22, s. 24 (4) related to air temperatures - CDD - August 9, 2024.
- Follow-up #: 1 - CO #007, O. Reg. 246/22, s. 102 (7) 11 related to hand hygiene program - CDD August 5, 2024.
- Follow-up #: 1 -CO #008, O. Reg. 246/22, s. 142 (1) related to recreational cannabis - CDD July 29, 2024.

- Follow-up #: 1 - CO #009, O. Reg. 246/22, s. 252 (3) related to police record checks - July 30, 2024.
- Follow-up #: 1 - CO #001, O. Reg. 246/22, s. 23.1 (1) related to air conditioning (AC) requirements - CDD July 12, 2024.
- Follow-up #: 1 - CO #003, O. Reg. 246/22, s. 23.2 (4) related to uninstalling AC - CDD - July 15, 2024.
- Follow-up #: 1 -CO #004, O. Reg. 246/22, s. 23.2 (8) related to portable AC installed CDD July 15, 2024.
- Follow-up #: 1 - CO #002, FLTCA, 2021, s. 82 (2) related to training - CDD July 30, 2024.

Previously Issued Compliance Order(s)

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

Order #006 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 102 (2) (b)
Order #005 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 24 (4)
Order #007 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 102 (7) 11.
Order #008 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 142 (1)
Order #009 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 252 (3)
Order #001 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 23.1 (1)
Order #003 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 23.2 (4)
Order #004 from Inspection #2024-1553-0003 related to O. Reg. 246/22, s. 23.2 (8)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:

Order #002 from Inspection #2024-1553-0003 related to FLTCA, 2021, s. 82 (2)

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

Safe and Secure Home
Infection Prevention and Control
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Licensee must comply

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee has failed to comply with Compliance Order (CO) #002 from Inspection #2024-1553-0003 served on June 26, 2024, with a compliance due date of July 30, 2024.

The required staff education did not include training in all areas required under FLTCA, 2021, s. 82 (2) for all security staff, other agency staff and newly hired staff working in home.

Rationale and Summary

The written process developed and training provided to agency staff and all newly hired staff under FLTCA, 2021, s. 82 (2) did not include the required training according to all Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that were relevant to the person's responsibilities, prior to working in the home.

The documentation provided did not include the content of the training that was provided, a signature of the agency staff who received the training, a date the training was provided, and the results of the testing for staffs' knowledge of the training received.

The Associate Director of Care (ADOC) and the Administrator acknowledged the requirement for staffs' training under the FLTCA, 2021, s. 82 (2) was not completed for all security staff, other agency staff and newly hired staff working in home.

Failure to ensure that all security staff, other agency staff and newly hired staff completed the required training placed the residents at risk of harm.

Sources: CO #002, policies, New Employee Orientation Guide, staffs surge learning records, interviews with the ADOC and the Administrator.

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001

Related to Written Notification NC #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP 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 AMP.

WRITTEN NOTIFICATION: Communication and response system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (g)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is

equipped with a resident-staff communication and response system that,
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

The licensee has failed to ensure that in the case of a system that uses sound to alert staff, was properly calibrated so that the level of sound was audible to staff.

Rationale and Summary

During a observation, Inspector noted a call bell was ringing. No staff could be found on the unit. A PSW indicated that they were off the unit and staff on a separate resident home area (RHA) were to answer the call bells when this occurred.

The Administrator confirmed the home's communication system was an audible system and that staff working on the other RHA could not hear the call bell if a resident was ringing for assistance.

There was an increased risk to the resident's safety as staff were not alerted to respond to the resident's needs increased risk to the resident's safety as staff were not alerted to respond to the resident's needs.

Sources: Observations, interviews with staff and the Administrator.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to implement the standard or protocol issued by the Director with respect to infection prevention and control (IPAC).

According to the IPAC Standard for Long-Term Care Homes (LTCHs) dated September 2023, section 9.1 directed the licensee to ensure that Routine Practices and Additional Precautions were followed in the IPAC program, specifically 9.1 (d) referring to proper use of Personal Protective Equipment (PPE), including appropriate selection, application, removal, and disposal for additional precautions.

Rationale and Summary

Two residents required additional precautions; staff were required to apply Personal Protective Equipment (PPE) when providing direct care.

A nurse was providing a resident's footcare. They were not wearing appropriate PPE. The nurse indicated they were not aware the resident required additional precautions and they should have been wearing the appropriate PPE.

A Personal Support Worker (PSW) was observed exiting a resident's room and removing their PPE incorrectly. The PSW acknowledged their technique for removing their PPE was not according to how they had been trained.

The IPAC lead indicated staff were required to perform hand hygiene, and apply the

appropriate PPE. They further indicated when exiting a resident's room staff were required to remove their PPE, and then perform hand hygiene.

There was a risk of transmission of infectious agents when staff did not apply and remove PPE correctly.

Sources: The IPAC Standard for LTCHs, observations, and interviews with staff, and interview with the IPAC lead.

COMPLIANCE ORDER CO #001 Protection from certain restraining

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 34 (1) 5.
Protection from certain restraining
s. 34 (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than under the common law duty referred to in section 39.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee shall:

The Administrator or Management designate will remove barriers, locks and controls to ensure that no resident is restrained from having access to resident dining room areas and designated cooling areas. The Administrator or Management designate will audit twice a day, once on days and once on evenings for two weeks, then every other day for two weeks, to ensure that the dining room doors are open. If the dining room door is noted to be shut or locked the designate completing the audit will provide education to the staff working on the unit. Keep a documented record of the audit including the name of the designate completing the audit, the date, the time, whether the dining room door was shut or locked, and the names of the staff educated and what education was provided when the dining room door was observed shut or locked. Provide this document immediately upon request of the Inspector.

Grounds

The licensee has failed to ensure that no resident in the home, was restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than under the common law duty referred to in section 39.

Rationale and Summary

During a tour of the home two resident dining rooms were locked, these areas were also the residents designated cooling areas. A Housekeeper confirmed the resident dining room should not be locked. The dining room door was locked the next day and a PSW opened the dining room door. The PSW reported the dining room was usually locked.

The Administrator confirmed that the dining room doors should not be locked, and residents should have access to them, and the dining rooms were also the designated cooling areas, except for one. The Administrator agreed there was a risk to resident safety when the dining room door was locked with a resident inside.

The following week, the doors of two of the dining areas that were also designated cooling areas were shut tight. Residents that were not cognitive or in wheelchairs would not have access to these areas. A Registered Practical Nurse (RPN) agreed the dining rooms were the residents designated cooling areas, and all residents should have access to this space.

The Acting Director of Care (DOC) agreed that when the doors to the dining room were shut this was a barrier and would prevent access to this area to residents in wheelchairs and residents that were not cognitive .

By failing to allow residents access to the home's dining rooms also the designated cooling areas, the licensee impacted the resident's quality of life by reducing their living space outside their home areas. When the resident was observed in the dining room and the door was locked the resident's health may have been at risk if there was a medical emergency and staff did not have the key to open the door.

Sources: Observations, interview with staff and the Administrator.

This order must be complied with by November 1, 2024

COMPLIANCE ORDER CO #002 Cooling requirements

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 23 (2) (c)
Cooling requirements
s. 23 (2) The heat related illness prevention and management plan must, at a minimum,
(c) identify specific interventions and strategies that staff are to implement to prevent or mitigate the identified risk factors that may lead to heat related illness and to prevent or mitigate the identified symptoms of such an illness in residents;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee shall:

1. Provide Registered staff, PSW, all agency PSW and agency Registered staff and all Management staff education on the heat related illness and management plan identifying specific interventions and strategies that staff were to implement to prevent or mitigate the identified risk factors that may lead to heat related illness and to prevent or mitigate the identified symptoms of such an illness in residents. Keep a documented record of the date, staff names, staff signatures, the content of the education provided, and how this education was provided.

2. As per the home's Heat Related Illness Plan which indicated the plan would be in effect in the months of May to September of each year and when the temperature was twenty-six (26) degrees Celsius or over. Nursing Staff shall implement interventions identified on the care plan for all Residents identified as being at high

or moderate heat risk as indicated by the Heat Risk Assessment (completed quarterly by RAI and found in PCC). The DOC or designate within one week of receiving the Licensee Report will audit all resident care plans to ensure they are updated with resident specific interventions as per the Heat Related Illness and Prevention plan. Keep a documented record of the resident's name, the date, and indicate if the care plan was up to date. Provide the documented records upon request of the Inspector.

3.The DOC or designate will develop a process to ensure all resident care plans are updated prior to May 15 annually as per the home's Heat Prevention and Management Plan to include each resident has specific interventions and strategies implemented to prevent or mitigate the risk factors. Keep a documented record of the plan developed and provide the document upon request of the Inspector.

Grounds

The licensee has failed to identify specific interventions and strategies that staff were to implement to prevent or mitigate the identified risk factors that may lead to heat related illness and to prevent or mitigate the identified symptoms of such an illness in residents.

Rationale and Summary

During an observation, a few resident portable air conditioning units were observed to be turned off.

The home's policy indicated that during the hot weather months all residents shall be monitored for signs of heat stress and dehydration. Nursing staff shall implement interventions identified on the care plan for all residents as being at high or

moderate risk as indicated by the heat assessment scale.

Review of the daily recorded air temperatures indicated the rooms air temperature was 26 degrees Celsius and above on multiple occasions, over a couple of weeks. Review of the residents care plans identified there were no interventions, or resident monitoring for signs of heat stress and dehydration as part of the heat related illness prevention and management plan.

The Acting DOC agreed that the residents should have individualized care plans as part of heat related illness prevention and management plan. The Acting DOC and Administrator indicated the care plans should have been updated to include interventions to be implemented, for monitoring signs of heat stress and illness, prior to May 15, 2024, as part of the heat related illness prevention and management plan.

Failing to ensure the residents care plans were updated with interventions and monitoring put the residents at risk for heat related illness, when the heat prevention management plan needed to be implemented due to an increase in air temperatures in the home.

Sources: the home's policy, resident's clinical records, interview with the Acting DOC, and the Administrator.

This order must be complied with by November 1, 2024

COMPLIANCE ORDER CO #003 Training

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 82 (2) 10.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee shall:

1. The management team, led by the Administrator, will provide training in all areas required under FLTCA, 2021, s. 82 (2) to all staff working in the home.

2. A written record of all training along with a record of demonstrated knowledge of the training is to be kept. This record will include what training was provided, who provided the training, a record of the knowledge test, the date and time the education was provided as well and the name and signature of the staff who received this training. These records are to be made available to the inspector immediately upon request.

3. The Administrator will develop a process to ensure that the training for all staff meets the requirement for training under FLTCA, 2021, s. 82 (2), as well as any other required training specific to their role, prior to working in the home.

4. The Administrator or a management designate will conduct an audit of all staff working in the home to ensure that the required training under FLTCA, 2021, s. 82 (2) has been completed. The audit will include the name of the staff, date of hire, designated position, a list of all the training topics required specific to the staffs' role and responsibilities, and the date of the training for each topic completed by the staff. Any deficiencies identified will be recorded and those staff are to be immediately trained in accordance with the legislated requirements. A documented record is to be kept of this audit including the corrective action and made immediately available to the inspector upon request.

Grounds

The licensee has failed to ensure that no person performed their responsibilities before receiving training in all Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that were relevant to the person's responsibilities.

Rationale and Summary

A follow up inspection related to s. 82 (2) of the FLTCA, 2021 identified that several staff working in the home had not received all the required training, including policies of the licensee that were relevant to the person's responsibilities, prior to working in the home.

The ADOC and the Administrator both reported that surge learning, and the New Employee Orientation Guide were considered the main source of staff education. They further acknowledged that the training requirements under the FLTCA, 2021, s. 82 (2) were not met when several policies of the licensee were not part of the staffs'

education.

Failure to ensure that all staff completed the required training placed the residents at risk of harm.

Sources: New Employee Orientation Guide, staffs surge learning records, interviews with the ADOC and the Administrator.

This order must be complied with by November 29, 2024.

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #002
Related to Compliance Order CO #003

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

CO #002 issued on June 26, 2024 related to FLTCA, 2021, s. 82 (2) Orientation/Training in #2024-1553-0003 with a CDD of July 30, 2024.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP 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 AMP.

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal

to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.