Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 12, 2013	2013_049143_0042	O-00615-13,000705,000215	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF NORTHUMBERLAND
983 Burnham Street, COBOURG, ON, K9A-5J6

Long-Term Care Home/Foyer de soins de longue durée

GOLDEN PLOUGH LODGE
983 BURNHAM STREET, COBOURG, ON, K9A-5J6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

PAUL MILLER (143)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 1st, 6th, 7th and 12th, 2013.

During the course of the inspection, the inspector(s) spoke with The Administrator, the Director of Nursing, an Assistant Director of Nursing, a Registered Nurse, a Registered Practical Nurse, a Personal Support Worker and residents.

During the course of the inspection, the inspector(s) reviewed abuse, responsive behaviours and Critical Incident policies and procedures, completed tours of two resident home areas, observed resident and staff interactions and reviewed resident health care records inclusive of plans of care, assessments, progress notes and external referrals.
Critical Incident log O-000737-13 was also reviewed as part of this inspection.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The following finding is related to log #O-000737-13:
On a specified date resident #2 and #5 had a physical altercation. Resident #2 sustained an injury. On August 6th, 2013 Critical Incident Report (CIS) M531-000027-13 as well as resident #5 plan of care was reviewed with the Director of Nursing. The CIS submitted indicated that resident #5 responsive behaviours were triggered by resident #2 inactivity (sitting doing nothing). A review of the residents plan of care did not identify this or any other potential behavioural triggers. The Director of Nursing confirmed with the inspector that the plan of care did not identify any behavioural triggers.

The licensee has failed to comply with Ontario Regulation 79/10 section 26.(3) 5. by not ensuring that the plan of care identifies potential behavioural triggers. [s. 26. (3) 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 to ensure that all residents with responsive behaviours have their plan of care reviewed and revised to ensure that potential triggers to behaviours are identified within the plan of care, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The following finding is related to log O-000215-13:
On a specified date resident #2 grabbed and pushed resident #3. Resident number #3 did not sustain any physical injury and did not complain of any pain from the altercation. A CIS (Mandatory Report, abuse/neglect) was submitted to the Ministry of Health and Long Term on a specified date. Two days after the CIS was submitted additional information was requested of the licensee by the Central Intake and Assessment Team of the Ministry of Health and Long Term Care. On August 1st, 2013 the CIS was reviewed and discussed with the Assistant Director of Nursing (ADON). The ADON confirmed with the inspector that an amended CIS was not completed and that the home had not submitted a final report of the results of the homes investigation to the Director (Ministry of Health and Long Term Care).

The following finding is related to log O-000615-13:
On a specified date a PSW (S102) overheard resident #1, visitor address her/him in a loud voice and then heard what sounded like a slap, skin on skin. S102 assessed resident #1 and documented that he/she had a red mark. On a specified date a critical incident report (CIS) was submitted to the Ministry of Health and Long Term Care reporting a mandatory report category abuse/neglect. Thirty two days following the incident an amended CIS was submitted to the Ministry of Health providing the outcome of the results of the homes' abuse investigation.

The licensee has failed to comply with Ontario Regulations 79/10 section 104.(3) by not ensuring that the final report was submitted to the Director within twenty-one days as specified in the March 28, 2012 memorandum to Licensees/Long-Term Care Homes from Acting Director Karen Slater. [s. 104. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a final report is provided to the Director within twenty-one days of all incidents of alleged abuse or neglect of a resident, to be implemented voluntarily.

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Issued on this 12th day of August, 2013

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