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
Mar 4, 2014	2014_049143_0006	O-000012-14	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

PAUL MILLER (143)

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): February 6th-7th, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, two Assistant Directors of Care and the complainant.

During the course of the inspection, the inspector(s) reviewed a resident health care record inclusive of assessments, physician orders, care plans, referrals and reviewed discharge policies and procedures.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Quality Improvement

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. On a specified date Resident #1 demonstrated responsive behaviors. Resident #1 was transferred to hospital.

On a specified date Resident #1 was provided a written notice indicating that he/she was discharged from the home.

On February 6th, 2014 the Director of Care reported to the inspector that the home had not ensured alternatives to discharge had been considered, no discussions occurred with placement co-ordinator and other health service organizations in respect of alternative accommodations and that the home did not ensure that Resident #1 and the resident's substitute decision-maker were given and opportunity to participate in the discharge planning prior to being discharged.

It should be noted that Ontario Regulation 79/10 section 148.(2)(d) was not issued as part of these findings. [s. 148. (2)]

The licensee has failed to comply with Ontario Regulation section 148. (2)(a)(b)(c) by not ensuring alternatives to discharge are consider, by not collaborating with placement co-ordinator and other health service organizations in order to make alternative arrangements for accommodation and by not ensuring the resident and the resident's substitute decision-maker is given an opportunity to participate in discharge planning.

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 prior to discharging a resident that alternatives to discharge are considered, the placement co-ordinator and other health service organization be consulted and that the resident and that the resident's substitute decision-maker, if any, is kept informed and given an opportunity to participate in the discharge planning, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. On a specified date Resident #1 demonstrated responsive behaviors. Resident #1 was transferred and admitted to hospital. A letter was forwarded to Resident #1 advising him/her that he/she was discharged.
On February 6th, 2014 Golden Plough Lodge, Director of Care reported to the Nursing Inspector that prior to the resident receiving the letter of discharge that had no time staff discussed with the resident any plans to discharge him/her.
The Licensee has failed to comply with the Long Term Care Homes Act 2007, section 3.(1)9. by not ensuring the resident right to participate in decisions is respected. [s. 3. (1) 9.]

WN #3: 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. Ontario Regulation 79/10 section 30. (1) states that every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to

specialized resources where required.

Golden Plough Lodge Policy No.:CN2-22 (Clinical Nursing Manual) Discharge and transfer of an Elder pg 1 of 3 states the following:
Policy:
All Elders shall be discharged to the community or to an alternate Long-Term Care Home in accordance with the Long-Term Care Homes Act and its associated Regulations.
Additionally, before discharge occurs, the Home shall ensure that alternatives to discharge have been considered and tried and, if not successful, shall assist in planning for discharge by identifying alternative accommodations, health service organizations and other resources in the community which the Elder may require, or shall refer the Elder to such organizations and resources.
Procedure 5. Indicates the following.
The Nurse in Charge is to have the Elder's Attending Physician document the discharge on the Elders chart.

On a specified date Resident #1 demonstrated responsive behaviors. Resident #1 was transferred to hospital.
On a specified date Resident #1 was provided a written notice indicating that he/she was discharged from the home.

On February 6th, 2013 the Director of Care reported to the inspector that the home had not ensured alternatives to discharge had been considered and that no discussions occurred with placement co-ordinator and other health service organizations in respect of alternative accommodations prior to discharging Resident #1.

A review of the health care record indicated that the attending physician had not documented that the resident had been discharged and had not written an order discharging the resident from the Nursing Home.

The Licensee has failed to comply with Ontario Regulation 79/10 section 8.(1)b by not ensuring that the discharge policy and procedure was complied with. [s. 8. (1)]

Issued on this 5th day of March, 2014

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

P Miller