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

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 20, 2015	2015_280541_0006	O-001516-15	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

AMBER MOASE (541)

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): February 10-12, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Associate Directors of Care, the Physiotherapist, a Registered Practical Nurse, Personal Support Workers. In addition, the Inspector also reviewed a resident's health care record, reviewed Falls Management policy and observed residents in the common areas.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The home has failed to ensure that the Resident #1 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

As per Resident #1's progress notes, on three separate and specified dates, Resident #1 fell from his/her bed. The fall on January 9, 2015 resulted in an injury and hospitalization.

On the specified date of the first fall, Resident #1 was found on the floor, landed on falls mat and had no injury. The falls note completed on the date of the fall states the resident had received a suppository for bowel protocol and staff queried if Resident #1 was restless as a result of receiving suppository. A post-fall assessment completed the date of the fall as well as the Fall Resident Assessment Protocol (RAP) completed twenty days following the fall, indicate the cause of Resident #1's fall on a specified date was receiving a suppository.

On the specified date of the second fall, Resident #1 sustained another fall from bed, again landing on the fall mat and no resulting injury. The DOC confirmed during an interview with Inspector #541 that there was no post fall assessment completed for this fall therefore the cause of the fall was not determined.

On the specified date of the third fall Resident #1 sustained another fall from bed, this time sustaining an injury. Resident #1 was sent to the hospital and had surgery as a result of the injury received from the fall.

During an interview with Inspector #541 on a specified date,PSW staff member #S103 stated he/she was working on the specified date of the third fall when Resident #1 received an injury. PSW #S103 stated that when Resident #1 fell, he/she did not land on the fall mat as it appeared the Resident had gotten up due to being incontinent and had fell just past where the mat was laying. A post fall assessment completed on the specified date of the fall indicates the cause of Resident #1's fall was "resident received a laxative".

During an interview with Inspector #541 PSW staff members #S106 and #S107 could not indicate any circumstances that may put Resident #1 at risk of falls. 2 of the 3 falls Resident #1 had it was indicated in the post falls assessment the cause of Resident #1's

falls were receiving a suppository.

Resident #1's care plan in effect at the time of each fall and in effect at the time of this inspection, does not reflect the risk of Resident #1 falling after receiving a suppository.

The home failed to revise Resident #1's plan of care to reflect the risk of falling after receiving a suppository as identified as the root cause of 2 out of 3 falls. [s. 6. (10) (b)]

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 ensure that all residents are reassessed and the plan of care reviewed and revised when a resident has had a fall and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

Issued on this 3rd day of March, 2015

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

Original report signed by the inspector.