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 2, 2013	2013_031194_0021	000343-13	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

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 30, 31 and August 01, 2013.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Assistant Director of Care(ADOC), Two Registered Nurse (RN), Registered Practical Nurse (RPN), and three residents.

During the course of the inspection, the inspector(s) reviewed the clinical health record for a resident, licensee's policy #CN6-06, policy #CN6-07, Policy New-Orders-Transcribing III.03 and observed resident/staff interaction for the provision of care.

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

Nutrition and Hydration

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

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg s.6(5) when there was a change in condition for resident #1 and the Substitute Decision Maker (SDM) was not notified, as agreed by the home. A medication change was implemented and resident #1 was not notified.

-staff #103 RN, assessed resident #1 and determined a change in condition. SDM was informed of the change in condition, two days later.
-staff #101 RN, confirmed that resident #1 was capable of making decision related care but that an agreement had been reached with the home in 2012 that the SDM's would be called with any change in condition.
-On May 29, 2012 a care conference was held for resident #1 stating that the family was to be notified although resident was capable of making decisions [s. 6. (5)]

2.
-A three month medication review for resident #1 was completed by the physician, where a medication was discontinued.
-Resident #1 stated having no knowledge that the medication had been discontinued.
-Staff #101 RN, stated that it was the home's practice to notify SDM's with changes in medication.
-Review of the progress notes for resident #1 was completed by the inspector and there was no documentation to verify that the resident had been informed of the medication being discontinued.
-Pharmacy Policy III.03 "New orders-transcribing" directs staff to notify the resident or Power of Attorney (POA) of medication changes.
-The Medication Administration record (MAR) for resident #1 was reviewed, for the month in which the medication was discontinued and it confirmed that the medication was not administered to the resident. [s. 6. (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 ensuring that the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are notified with changes in condition and medication changes so that they are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours. O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. s. 107(3)4 when resident #1 was injured and sent to hospital and the Director was not notified.

-The progress notes for resident #1 indicates that staff #101 RN, documented on an identified date, that the resident sustained and injury during a transfer. The resident was sent to hospital and returned with a diagnosed injury.
-A review of the MOHLTC web-site for Critical Incidents (CI) for the period three months after the incident occurred and there was not a CI submitted for the incident.
-Interview with staff #101 RN, ADOC and DOC have confirmed that no Critical incident for this incident was submitted to the MOHLTC.
-A revision of the licensee's policy EC18-03 on Critical Incident was completed on August 2012. [s. 107. (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 ensuring that the Director is informed of an injury in respect of which a person is taken to hospital, to be implemented voluntarily.

Issued on this 2nd day of August, 2013

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

Chantal Jafreniere (194)