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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 8, 2014	2014_179103_0012	O-000347-14	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

DARLENE MURPHY (103)

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): May 6-8, 2014

During the course of the inspection, the inspector(s) spoke with a Registered Practical Nurse (RPN), a Registered Nurse (RN), and the Director of Care.

During the course of the inspection, the inspector(s) made resident observations, reviewed the resident health care record, and the home's emergency plan related to fire.

The following Inspection Protocols were used during this inspection:

Responsive Behaviours
Safe and Secure Home

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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Regs 79/10 s. 107 (1) 1. whereby an emergency was not immediately reported to the Director.

On an identified date, the bedsheets on a resident bed were found in flames. Cigarette butts were also located in the resident garbage. Approximately two hours later, a privacy curtain was discovered smoldering in an adjacent resident room.

The Assistant Director of Care notified the Ministry of Health and Long Term Care of the two incidents for the first time approximately five hours after the discovery of the first fire. [s. 107. (1) 1.]

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 an emergency, including fire is immediately reported to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Regs 79/10 s. 30 (2) whereby actions taken with respect to a resident assessment were not documented.

Registered staff were interviewed to determine the interventions in place to monitor Resident #1's behaviours. Staff stated the resident is being monitored every fifteen minutes and that a DOS had also been started to track the resident's behaviours. Staff also stated this information was important as it would be utilized by the geriatric psychiatry team when the resident was reassessed on an identified date.

The resident DOS and the every fifteen monitoring sheets were reviewed for an identified period of time. There were identified periods of time whereby the resident's whereabouts or behaviours were not documented on either of the monitoring tools.

Issued on this 8th day of May, 2014

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