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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 26, 2018	2018_694166_0003	014923-17, 015129-17, 015132-17, 017691-17, 023043-17, 023284-17, 024694-17, 028755-17	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

CAROLINE TOMPKINS (166)

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): January 23, 24, 25, 26, 30, 2018

Critical Incident Logs #04694-17, #017691-17 related to allegations of resident to resident physical abuse, #023284-17, #014923-17 related to allegations of staff to resident verbal/physical abuse, #023043-17, #015129-17, #015129-17 related to missing resident, log #02205-17 and #027855-17 related to falls that resulted in injury were inspected concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Life Enrichment staff(LE), Personal Support Workers(PSW), Registered Practical Nurses(RPN), Registered Nurses(RN), Nursing Clerk, Resident Assessment Instrument Coordinator(RAI), Assistant Director of Care(ADOC), Resident and Family Services Manager and the Director of Care(DOC).
During the course of this inspection, the inspector observed staff and residents during the provision of care, reviewed clinical documentation, the licensee's investigation documentation and relevant policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **2 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. related to 014923-17

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #006 as specified in the plan.

A Critical Incident Report (CIR) was submitted to the Director reporting an alleged incident of staff to resident verbal and emotional abuse.During a meal service resident #006 was displaying verbally responsive behaviours. RPN #112 was becoming irritated and repeatedly asked the resident #006 to quiet down or the resident would be administered a specific medication. This verbal interaction by RPN #112 directed towards resident #006 was done in a voice loud enough to be heard by staff and overheard by a co resident's family member.

RPN #112, called RN #113, who then took resident #006 to sit in a quiet environment. Resident #006 was upset and agitated and unable to self calm, RN #113 then administered a prescribed medication.

Review of resident #006's plan of care related to responsive behaviours indicated:
staff are to:
- Approach the resident slowly and from the front
- Be cognizant of not invading personal space
- Discuss options for appropriate channeling of behaviours

Remove resident from public area when behavior is disruptive/ unacceptable.
Talk to resident in a direct, calm, firm voice to decrease/eliminate undesired behavior.

During the course of the interaction between RPN #112 and resident #006, the plan of care for the resident related to the management of responsive behaviours was not provided to resident #006 as specified in the plan. [s. 6. (7)]

2. related to log 028755-17

The licensee has failed to ensure that the plan of care was provided to resident #007 as specified in the plan.
A Critical Incident Report (CIR) was submitted to the Director reporting an injury to resident #007 for which the resident was taken to the hospital and which resulted in a significant change in the resident's health status.

Review of the CIR, the Life Enrichment Team had taken several residents on an bus tour. After tour was finished and the bus returned to the home, all the residents on the bus were advised to remain seated and continue to wear their seat belts. LE #101 got off the bus and went into the home entrance to retrieve the residents' mobility aides to assist with disembarking.
LE#114, remained on the bus with residents. When a co resident became agitated and insisted on getting off the bus, LE#114 assisted the co resident off the bus .
The CIR documentation indicates that while LE#114 was off the bus and the bus door was open, resident #007 removed the seat belt, went to the open door of the bus, took a step down and fell from the top step onto the pavement and sustained an injury.
Resident #007 was assessed and transferred to the hospital for further assessment.
Resident #007 was admitted to the hospital and did receive further treatment.

Review of the plan of care for resident #007 related to mobility and transfers indicated:
Requires assistance to prevent decline of functioning for TRANSFERRING from one position to another related to: unsteady gait
TRANSFERS: One-Two staff to pivot/transfer
Staff to supervise - resident requires assist x 1 staff
The plan of care for resident #007 related to mobility and transfers was not provided to resident as specified in the plan. Resident #007 was not supervised/assisted as the resident attempted to disembark the bus resulting in a fall with injury and a significant change in condition. [s. 6. (7)]

3. related to log 024694-17

The licensee has failed to ensure that if resident #009 is being reassessed and the plan of care is being revised because care set out in the plan had not been effective, different approaches had been considered in the revision of the plan of care.

A Critical Incident Report (CIR) was submitted to the Director related to a resident to resident physical abuse incident.

Review of clinical documentation and interview with the ADOC indicated, resident #009, had ongoing responsive behaviours which included targeting specific residents, hitting, spitting, physical and verbal aggression directed towards co residents.

Resident #009 was admitted to a specialized resource unit for the assessment and management of the resident's ongoing responsive behaviours.
Interview with the ADOC indicated, when resident #009 returned to the home, recommendations were provided by the specialized resource unit to help the staff manage the resident's responsive behaviours with interventions that were effective.

Review of the recommendations indicated:
-always allow resident to have a specific item with them at all times
-Keep co patients who tend to wander in w/c and bump into resident #007 away (this upsets the resident as the resident believes they do it on purpose)
-take resident to a quiet spot...
-use craft activities to distract...
- routinely offer to take the resident to the toilet...increase frequency of toileting...not able to find the toilet on own this upsets resident...does not like to have accidents
take the resident for a walk of the unit..... or outdoors to calm the resident down
-offer to sit , do certain activities and chat to calm the resident ...offer a cold drink and snack
-enjoys looking at pictures of specific animals and people
-seat with residents who are higher functioning and can still demonstrate social skills
-loves specific songs and music and will listen to music on tape
-encourage rest on bed after lunch play classical music
-responds to comforting hugs and reassurances, this helps to calm the resident
-likes to be close to people the resident trusts (staff)
-give lots of compliments as this boosts the resident's self esteem
-always thank the resident for everything the resident has done , even during care, the resident needs to feel has contributed something
-Behaviour is triggered by co residents that are intrusive or who may have bumped into

the resident
-Reassure +++++ that you are looking out for the resident

Review of resident #009's plan of care related to the management of responsive behaviours indicated:
• Allow resident time to respond to directions or requests
• Approach the resident slowly and from the front
• Be sure you have the resident's attention before speaking or touching
• Remove to a quiet area. Spend time with resident & reassure res. of personal safety and stay with res during periods of anger if appropriate or if res. wishes.
• Allow for flexibility in ADL routine to accommodate resident's mood..
• Praise/ reward resident for demonstrating consistent desired/ acceptable behavior
• Try to redirect undesirable behavior; anger, unrealistic fears, repetitiveness.
• Allow resident to wander on unit
• Does not like residents getting into personal space

Resident #009's plan of care related to responsive behaviours, post admission from the specialized resource unit, post incident and reassessment of resident #009's plan of care, does not identify different approaches to resident #009's responsive behaviour or that the recommendations of the specialized resource unit had been considered in the revision of the plan of care. [s. 6. (11) (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 to ensure that the care set out in the plan of care is provided to the resident as specified in the plan and a when the resident is reassessed and the plan of care reviewed and revised, because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care (2007,c. 8, s. 6 (7), c. 8, s. 6 (11)), to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. related to log 023284-17

On a specified date a Critical Incident Report was submitted to the Director, reporting an alleged incident of staff to resident physical abuse.
Review of the CIR documentation indicated, resident #005 reported to a care giver, that on a specified date and time, the resident had used the nurse call bell and PSW #107, who responded to the call was rough, had grabbed and hurt the resident when the resident was trying to get up.

Review of the licensee's investigation documentation and interview with the DOC and ADOC indicated, during the same shift , resident #005 rang the nurse call bell a second time and PSW #108 responded. Resident #005 told PSW #108, that PSW#107 was rough had hurt resident #005 and the resident was not happy.

The licensee's investigation documentation indicated PSW #108 did inform RPN #109, that resident #005 was not happy with PSW #107.
The licensee's investigation and interview with the DOC indicated, RPN #109's statement was that PSW #108 did not provide any other details.
RPN #109 did not investigate further why resident #005 was not happy with PSW#107.

Review of the licensee's policy related to Incident Reporting, Prevention of Abuse and Neglect indicates:
The Reporting of Abuse
Staff and Volunteers of the Golden Plough Lodge who witness or suspect the abuse of a resident or who receives complaints of abuse, MUST report the matter without delay to their immediate supervisor

The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with. [s. 20. (1)]

2. related to 014923-17

The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with
.
A Critical Incident Report (CIR) was submitted to the Director reporting an alleged incident of staff to resident verbal and emotional abuse
.During a meal service resident #006 was displaying verbally responsive behaviours. RPN #112 was becoming irritated and repeatedly asked the resident #006 to quiet down or the resident would be administered a specific medication. This verbal interaction by RPN #112 directed towards resident #006 was done in a voice loud enough to be heard by staff and overheard by a co resident's family member

RPN #112, called RN #113, who then took resident #006 to sit in a quiet environment. Resident #006 was upset and agitated and unable to self calm, RN #113 then administered a prescribed medication.

Interview with RN#113, indicated , the RN had received a call from RPN #112, advising that resident #006's behaviour required removing the resident from a common area. The RN assisted resident #006 to a quieter environment to allow the resident to calm down. Resident #006 was upset and agitated and unable to self calm, RN #113 then administered a prescribed medication.
During the interview RN#113, indicated not being informed of RPN #112's response to resident #006's responsive behaviour and therefore was unaware of the alleged staff to resident verbal abuse until informed by the ADOC four days post incident.

Review of the licensee's investigation and interview with the ADOC indicated the PSWs and the Dietary Aides who witnessed the incident of staff to resident verbal abuse did not report the details of the witnessed incident to RN #113.

Review of the licensee's policy related to Zero tolerance of resident abuse directs all staff and volunteers to immediately report without delay to their immediate supervisor any witnessed, alleged or suspected incidents of any resident abuse.
The ADOC received written accounts of the incident submitted by the Dietary and PSW staff who witnessed the incident, four days after the incident had occurred.
[s. 20. (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 that the licensee's written policy to promote zero tolerance of abuse and neglect of residents related to the immediate reporting of alleged, witnessed or suspected is complied with. 2007, c. 8, s. 20 (1)., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. related to log 023284-17

The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated.
A Critical Incident Report(CIR) was submitted to the Director reporting an alleged incident of staff to resident abuse.
Review of the CIR and clinical documentation indicated resident #005 reported to a care giver, that the resident had used the nurse call bell and PSW #107, who responded to the call was rough, had grabbed and hurt the resident when the resident was trying to get up.

Resident #005 also reported that during the interaction with PSW #107, the PSW allegedly told the resident not to ring the call bell and that the resident was not getting up.

The licensee did conduct an internal investigation related to allegation of staff to resident physical abuse.
Review of the licensee's investigation did not provide any evidence that the allegation related to the staff to resident emotional/verbal abuse was investigated.
Interview with the Director of Care and the Assistant Director Care indicated, the allegation of staff to resident emotional/verbal abuse related to the PSW #107's alleged comment that the resident was not to ring the call bell and was not getting up was not investigated. [s. 23. (1) (a)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. related to log 023284-17

The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

A Critical Incident Report was submitted to the Director, reporting an alleged incident of staff to resident physical abuse.
The alleged incident of staff to resident physical abuse was reported to the licensee by resident #005's private caregiver, resident #005 had used the nurse call bell and PSW #107, who responded to the call was rough, had grabbed and had hurt the resident when the resident was trying to get up.
The licensee initiated an internal investigation into the allegations.

Interview with the DOC and ADOC and review of the licensee's investigation documentation could not provide evidence that police were notified of the allegations of staff to resident physical abuse. [s. 98.]

WN #5: 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. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. related to log 023284-17

The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident:
(ii) names of any staff members or other persons who were present at or discovered the incident, and
(iii) names of staff members who responded or are responding to the incident

A Critical Incident Report (CIR) was submitted to the Director, reporting an alleged incident of staff to resident physical abuse.
Review of the CIR documentation indicated resident #005 reported to a private care giver, that the resident had used the nurse call bell and PSW #107, who responded to the call was rough, had grabbed and hurt the resident when the resident was trying to get up.

Review of the CIR submitted to the Director did not identify any staff members who were involved or who had responded to the incident. [s. 104. (1) 2.]

Issued on this 27th day of February, 2018

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

Original report signed by the inspector.