Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**
Amended

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
June 20, 21, 22, 25, 27, 28, 29, July 4, 5, 6, 9, 10, 11, 12, 13, 16, 17, 18, 19, 26, 30, 31, August 1, 2, 3, 2012.	2012_048175_0011	Critical Incident

Licensee/Titulaire
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(s)
BRENDA THOMPSON, (175)

Inspection Summary/Sommaire d'inspection

This report was amended as a result of the Director's Review. Written Notification (WN) #2 and Compliance Order 002 issued on August 3, 2012 were rescinded as a result of the Director's Review.

The purpose of this inspection was to conduct a critical incident inspection.

During the course of the inspection, the inspector spoke with the Coroner, Administrator, Director of Care (DOC), Associate Director of Care (ADOC), two Registered Nurses (RN), two Registered Practical Nurses (RPN), four Personal Support Workers, Environmental Services Manager, Administrative and Policy Co-ordinator, three residents on resident #1 and #2 home area.

During the course of the inspection, the inspector reviewed resident #1 and resident #2 clinical health records specific to Critical Incident issues, Resident Home Area Evening Routines, Maintenance Log, Room Change Sheet Res #1, and Elder Care Manual on resident #1,#2 home areas, Policies and Procedures-Critical Incidents, Prevention, Reporting and Elimination of Elder Abuse, Falls Management, Post-Fall Management, observed resident #1 and resident #2 rooms and an identified resident home area.

The inspection was conducted in the home on June 20, 21 and 22, 2012.

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

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

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 subsections:

s. 6(1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each

resident that sets out,

(a) the planned care for the resident;

(b) the goals the care is intended to achieve; and

(c) clear directions to staff and others who provide direct care to the resident.

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.

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;

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

(c) care set out in the plan has not been effective.

Findings:

1. Review of Health Care Record including Care Plan for resident #1 indicates resident #1 had a high risk for falls due to multiple factors. There were no clear directions to staff regarding nurse call device or the use of side rails/assist rails.

2.Interview with senior staff member confirmed the written need for side rails or any safety device should be documented in the resident care plan.

3. Interviews with two staff, indicated that for resident #1 the call bell pad and side rails/half rails, were always in use.

4.Interview with another staff member indicated resident #1 had identified communication deficits. It was further reported that the staff member could not remember giving resident #1 the call bell the day of the Critical Incident resulting in the resident's death.

5. Interview with a registered nursing staff member indicated side rails/half rails were always in use for resident #1.

6.Interview with senior staff members indicated that the staff did not have resident #1 call bell pinned or clipped to the resident.

The licensee failed to ensure that there was a written plan of care for resident #1 that set out clear directions to staff and others who provide direct care to the resident for the use of a call bell and the use of 2 assist rails.[Ref. s.6(1)(c)].

2. 1.Care Plan review for resident #1 identifies the resident was at high risk for injury/falls and indicates that the resident had a bed alarm in place on the bed. Interventions included that staff will ensure the bed alarm is functioning properly.

2.Nursing staff documented in the resident progress notes that on three occasions prior to the Critical Incident, staff witnessed that the resident had already fallen from the bed to the floor. There was no nursing documentation indicating the registered nursing staff acted to ensure the resident's personal alarm was functioning. In each incident, the resident had already fallen. A fourth fall from the bed to the floor was documented in nursing progress notes and indicated resident #1 was found and the bed alarm was not functioning. On the day of the Critical Incident resulting in resident death, there was no bed alarm device provided to resident #1.

3.Interview with a senior staff member, confirmed that about 6 months ago a staff member working in the home complained that resident personal alarms were too sensitive, staff did not know how to turn them off, so they unplugged them.

4.The personal alarm care intervention was not effective in alerting staff of the resident's increased movement prior to

experiencing a fall. The resident's needs related to high fall risk were not re-assessed and the care plan was not reviewed and revised when the resident's personal alarm was not effective.

5. Resident #1's care plan indicates the resident's continence issue is identified as the primary risk trigger for falls. Nursing progress notes reviewed, indicated that interventions to manage the resident's incontinence, to minimize the risk of falls, were not effective in prevention of falls on at least four occasions prior to the Critical Incident. Registered nursing staff neglected to manage the resident's continence needs to reduce the risk of falls.

6.Nursing RAI MDS Quarterly Assessment identified that resident #1's continence status had deteriorated and that the resident had fallen within the time frame being assessed. The resident's care plan was reviewed but not revised when the interventions to manage the resident's continence needs were ineffective.

7. Nursing progress notes were reviewed and indicated the resident fell from bed four times prior to the Critical Incident. The bedrails for resident #1, reported to be half rails, one on either side of the bottom half of the bed, were not effective care interventions to manage the resident's high risk for falls. There was repeatedly no documentation or report of any re -assessment of resident #1's safety needs related to the ongoing use of half rails.

8.Interview with identified Physician confirmed that the side rails/half rails were implicated in the Critical Incident resulting in the death of resident #1.

9.Physio Quarterly re-assessment was reviewed and indicates the resident risk of falls was "not applicable" and not assessed. Physio did not have the resident on a Falls Prevention Program despite the fact that Resident#1 experienced falls from the bed, documented on the nursing progress notes.
A second Physio Assessment, indicates incorrectly that resident#1 fell 1-2 times in a six month period. Review of resident Progress notes indicate resident#1 fell from bed four times in six months.

10.Nursing RAI MDS Quarterly Assessment identified that resident #1's continence status had deteriorated and the resident had fallen. Registered Nursing staff neglected to revise resident #1's plan of care related to high risk for falls and the impact the resident's deteriorating continence status had on further increasing the risk for falls.

The licensee failed to ensure that resident #1 was re-assessed and the plan of care reviewed and revised when the care set out in the plan of care was ineffective.[Ref. s.6(10(c)].

3. 1.Resident #1 risk for falls is characterized by multiple risk factors. Staff Interventions include the use of bed alarm when the resident is in bed. Ensure that it is working properly. Put bed in it's lowest position. Provide specific bedtime routine, provide continence care because it is a trigger for risk for falls. Keep resident's bed in the lowest position. Resident #1 is identified with a communication deficit related to a medical condition.

2.Interview with a senior staff member confirmed that staff directions for the use of personal alarms for residents is not documented anywhere in the home.

3.Interview with a second senior staff member confirmed that the care set out in the plan of care for resident #1 to address the high risk for falls was not provided to the resident as specified in the plan on the day of the Critical Incident resulting in resident death.

4.Resident #1's health record including progress notes by registered nursing staff was reviewed and indicated the care set out in the plan of care for resident #1 identified at high risk for falls, and with identified communication deficit, was not provided to resident #1 as specified in the plan on four incidents prior to the Critical Incident.

5.Interview with identified Physician regarding the Critical Incident resulting in the death resident #1 confirmed the fall was a primary implication in the death.

6.Care Plan review for resident #2 eight days following the Critical Incident of resident #1, specified that resident #2 is at risk for falls characterized by multiple risk factors. Interventions directed that staff will put bed alarm in place to alert staff so they can assist resident #2 whenever the resident is non-compliant in asking for staff assist.

7.Interview with Registered nursing staff member indicated that the staff member was not aware of the personal alarm

currently being used for resident #2, but knew it was supposed to be there because the person remembered the plan of care specifies resident #2 is to have a personal alarm.

8.Observation of resident #2 Room with a second Registered nursing staff member, confirmed the mechanism for a personal alarm on the head of the bed was not there. The Registered nursing staff member further reported that resident #2's plan of care says the resident is to have a bed alarm but that a while ago staff could not turn the personal alarms off - they were ringing when there was no need for them to be ringing. The only way to turn them off was disconnect them from the jack outlet at the base. Reportedly, Resident #2 has not had a bed alarm for more than 3 months. Resident #2 was not provided with a bed alarm to address falls risk, as specified in the plan of care reportedly for more than 3 months.

The licensee failed to ensure that the care set out in the plan of care for resident #1 and resident #2 was provided to the residents as specified in their plans, specifically related to both resident's high risk for falls.[Ref. s. 6(7)].

Inspector ID #:	175

Additional Required Actions:

CO #001 - A Director's Order was served on the licensee. Refer to the "Order(s) of the Director" form.
CO #005-A Director's Order was served on the licensee. Refer to the "Order(s) of the Director" form.
CO #006 –A Director's Order was served on the licensee. Refer to the "Order(s) of the Director" form.

WN #2: Rescinded

WN #3: The Licensee has failed to comply with O. Reg. 79/10, s.48. Required programs

s.48(1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.

Findings:

1. Policies and Procedures related to a Falls Management Program for residents, were reported by a staff member to be under revision for the last three months and were observed not to be available to direct care staff on a specific resident home area.

2.Falls Management Policy was reviewed and does not include home specific, interdisciplinary procedures for Falls Prevention. Staff are referred to the Physio Policy and Procedure Manual.

3.Post-Falls Management Policy was reviewed and does not include home specific interdisciplinary procedures to follow to prevent further falls, when a resident identified at high risk for falls/injury, experiences repeated incidents of falling without injury or hospitalization.

4.Interview with a senior staff member indicated the written need for side rails or any safety device should be documented on the care plan. It was further reported that there are no policies and procedures developed in the home

related to the use of resident personal bed or chair alarms used as a safety device to prevent falls or guidelines for staff to follow if the alarms are malfunctioning.

5.Care Plan for resident #1 at high risk for falls, with multiple risk factors was reviewed and indicated two half/assist rails and a nurse call bell, both safety devices, were not identified on the resident's care plan as a falls prevention intervention although they were reported to be in use.

6.Resident #1's health record including progress notes by RPNs was reviewed and indicated that resident #1 fell from the bed to the floor, four times prior to the Critical Incident.

7.Physio Quarterly re-assessment reviewed, indicates that resident #1's risk of falls was "not applicable" and not assessed. Physio did not have the resident on a Falls Prevention Program despite the fact that Resident#1 experienced 2 falls from the bed, for the relevant time period, that were documented on the resident #1's nursing progress notes.

8. A second Physio Assessment reviewed, indicates incorrectly that resident #1 fell 1-2 times, while a review of resident nursing Progress notes from date of admission indicated that resident #1 had fallen from bed four times in six months.

9.Nursing RAI MDS Quarterly Assessment identified that resident #1's continence status had deteriorated and that the resident had a fall during the review period. The resident's care plan indicated that the resident's continence status triggered the resident climbing out of bed. Resident #1's care plan was reviewed but not revised to include the resident's deteriorating continence status and potential implication for risk of falls.

10.Interview with an identified physician, confirmed resident#1's fall from bed was implicated in a Critical Incident resulting in death.

The licensee neglected to ensure an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury for resident #1 was developed and implemented in the home[Ref. Reg 79/10,s.48(1)1].

Inspector ID #:	175

Additional Required Actions:
CO # 003- A Director's Order was served on the licensee. Refer to the "Order(s) of the Director" form.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, section 19.(1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Findings:

1. Ontario Regulation 79/10, made under the Long Term Care Homes Act, 2007, defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety, or well-being of one or more residents.

The following occurrences demonstrate a pattern of inaction that jeopardized the health, safety and well-being of resident #1 related to the identified Critical Incident resulting in death:

1.Resident #1 risk for falls was identified by the home as being characterized by multiple risk factors. Interventions on the resident's care plan included that staff will ensure the bed alarm is functioning properly. Nursing staff documented in the resident progress notes that on three occasions prior to the Critical Incident, staff witnessed the resident had already fallen from the bed to the floor. There was no nursing documentation indicating the registered nursing staff acted to

ensure the resident's personal alarm was functioning. In each incident, the resident had already fallen. A fourth fall from the bed to the floor was documented in nursing progress notes and indicated resident #1 was found and the bed alarm was not functioning as it did not sound to alert staff resident was climbing out of bed. There was no documentation or staff report of any action taken by staff to communicate the malfunctioning alarm in the Maintenance Book, or ensure that the resident had a functioning safety device related to falls prevention. On the day of the Critical Incident, there was no bed alarm device provided to resident #1,in the resident's room.

2.Interview with a senior staff member confirmed that prior to the Critical Incident of resident #1, a staff member working in the home complained that resident personal alarms were too sensitive, staff did not know how to turn them off, so they unplugged them. The senior staff member reported that 1 staff member only was re-directed to the location of the re-set button. The senior staff member further reported that use of resident Personal Alarms in the home is not documented anywhere. The process is verbal, not written. There are no policies and procedures for the use of resident personal bed or chair alarms used as a safety device for falls prevention. Staff who unplugged/removed resident personal alarms neglected to priorize resident safety needs and jeopardized the health and safety of resident #1 and other residents identified to require personal alarms. Senior staff members neglected to communicate the need for all staff to receive education and training related to the correct/safe use of resident personal alarms as a safety device for residents, neglected to ensure that a policy and procedure for the use of personal alarms as a safety device for residents was developed and communicated to staff, neglected to ensure there was a system in place to monitor and maintain resident personal alarms as a safety device for resident #1.

3.Resident # 1's care plan indicates that resident#1's primary trigger for high risk for falls was related to continence issues. Staff interventions related to risk for falls include staff are to provide specific care. Resident#1 is also identified with a specific communication deficit related to a known medical condition. Interventions include staff are to provide daily routine to meet activities of daily living. The day of the Critical Incident, interviews with staff confirmed that resident #1 resident who had specific known communication deficit, was left, in bed, with the bed at an unsafe height, and without call bell access or a personal bed alarm to call staff for help or alert staff to the movement of the resident in bed.

4.Nursing progress notes indicated that interventions to manage the resident's incontinence, to minimize the risk of falls, were not effective in prevention of falls on at least four occasions. The day of the Critical Incident, staff neglected to manage the resident's known continence needs related to risk for falls. Registered nursing staff neglected to monitor resident #1 to ensure that effective continence care was provided to resident #1.

5.Nursing RAI MDS Quarterly Assessment identified that resident #1's continence status had deteriorated and the resident had fallen. Registered Nursing staff neglected to revise resident #1's plan of care related to high risk for falls and the impact the resident's deteriorating continence status had on further increasing the risk for falls.

6.The Falls Management Program currently in the home, directs all staff to follow the Policies and Procedures in the Physio Manual. Physio Quarterly re-assessment reviewed, indicates that resident #1's risk of falls was "not applicable" and not assessed. Physio did not have the resident on a Falls Prevention Program despite the fact that Resident#1 experienced 2 falls from the bed, for the relevant time period, that were documented on the resident #1's nursing progress notes. A second Physio Assessment reviewed, indicates incorrectly that resident #1 fell 1-2 times, while a review of resident nursing Progress notes from date of admission indicated that resident #1 had fallen from bed four times in six months. Physio staff neglected to correctly assess resident #1's risk for falls, to monitor the incidence of falls for resident #1 and to initiate a falls prevention program for resident #1 that could be shared with all other disciplines in the home, so resident #1's risk of falls could be managed/reduced.

7.Review of resident #1's health record indicated the bed rails for resident #1, reported to be half rails, one on either side of the bottom half of the bed, were not effective care interventions to manage the resident's high risk for falls. Registered Nursing staff neglected to follow the home's Policy and Procedure Bed and Assist Rails for resident #1 which directs staff to complete a needs assessment for the use of assist rails and staff engaging the side rails will ensure the resident's call bell is accessible to resident. Registered staff neglected to develop a plan of care for the use of assist rails, which includes the reason for their use, for resident #1. There were no specific directions regarding a call bell for resident #1. Specific directions were not provided for staff related to the use of side rails/assist rails. Registered nursing staff neglected to re-assess the use of assist rails for resident #1 after each of the four falls prior to the Critical Incident resulting in death.

8.Registered nursing staff repeatedly neglected to re-assess the falls risk of resident #1 according to RAI assessment

done for a specific time frame. No re-assessment observed related to resident #1's falls risk despite the fact that nursing Progress Notes for that time period indicated resident #1 had a fall. Review of RAP MDS Quarterly Assessment on a specific date indicated "No falls since the last identified quarter, which was incorrect, as resident#1 had experienced two falls in the identified time period. An RN documented a monitoring note for resident #1 medications and some health conditions, however, there was no re-assessment observed for resident #1's falls risk, indicating the resident's falls risk was not being monitored by nursing staff.

9.Interview with an identified Physician confirmed resident#1's fall from bed was implicated in the Critical Incident resulting in death.

The following occurrences demonstrate a pattern of inaction by the home that jeopardized the health, safety and wellbeing of other residents in the home post Critical Incident.

10.Interviews with a senior staff member confirmed that there is no facility specific, interdisciplinary process in place to guide the management of Critical Incidents involving residents.

11.Interview with a second senior staff member confirmed there was no review/investigation of resident #1's health care record, post fall, resulting in a Critical Incident and death, as part of the follow-up analysis to identify immediate corrective actions to prevent recurrence and protect other residents living in the home from potential harm/risk of harm.

12.Two senior staff members confirmed that the staff did not have the call bell pad pinned or clipped to resident #1 on the day of the Critical Incident.

13.Eight days post Critical Incident, a Memo to staff re ensuring all residents call bell access was sent to staff in all resident home areas.

14.Post Critical Incident interview with a senior staff member, confirmed that resident#1 did not have a personal alarm on the day of the Critical Incident resulting in resident death. The senior staff member reportedly did not know why the resident did not have a personal alarm. Immediate action was not taken to ensure the provision of resident personal alarms, reported to be a safety device in use in the home for residents identified at high risk for falls.

15.Care Plan review eight days post Critical Incident, for resident #2 specified that this resident is at risk for falls characterized by multiple risk factors. Interventions directed that staff will put bed alarm in place to alert staff so they can assist resident #2 whenever the resident is non-compliant in asking for staff assist.

16.Interview with a registered staff member indicated that the staff member was not aware of the personal alarm currently being used for resident #2, but knew it was supposed to be there. The registered staff member neglected to ensure resident #2 had a personal alarm in place to alert staff and manage the resident's high risk for falls.

17.Observation of resident #2 Room with a second Registered nursing staff member, confirmed the mechanism for a personal alarm on the head of the bed was not there. The Registered nursing staff member further reported that resident #2's plan of care says the resident is to have a bed alarm but that a while ago staff could not turn the personal alarms off - they were ringing when there was no need for them to be ringing. The only way to turn them off was disconnect them from the jack outlet at the base. Resident #2 was confirmed by staff not to be provided with a bed alarm for more than 3 months. Registered nursing staff on all shifts, including senior nursing staff, repeatedly neglected the identified safety need of Resident #2 for more than 3 months, when staff knew resident #2 was not provided with a bed alarm to address falls risk, as specified in the plan of care. The senior staff neglected to take immediate action to ensure that all residents identified at high risk for falls in the home, had a functioning personal alarm if the care plan of the resident(s) indicated it was an assessed safety need. Immediate corrective actions were not implemented to ensure that identified deficiencies regarding resident personal alarms were fully addressed.

18.Interview with an identified physician confirmed a plastic bag/garbage can insert was implicated in the Critical Incident resulting in resident death.

19.Senior staff confirmed that a decision was made, not to discontinue the use of the same plastic bag insert in resident garbage cans based on this one situation in all the years that the home had used that particular plastic bag insert would be overreacting. The decision was reportedly based on hygiene and infection control issues, not based on potential risk

of harm to residents.
20.Interview with senior staff member confirmed that there are two cognitively impaired, ambulatory residents currently in the home, specifically identified at risk for injury (Resident #3 and Resident #4) due to a related medical diagnosis. Observation of an identified Resident Home Area confirmed garbage cans with plastic bag inserts were observed to be accessible to several confused, ambulatory, wandering residents, including residents #3 and 4, in all resident bathrooms. Senior Management staff neglected to take immediate action to limit access to any and all residents in the home with the potential risk for harm related to the known circumstances of the Critical Incident resulting in resident death.

The licensee of the long term care home failed to ensure that residents are not neglected by the licensee or staff [Ref.LTCHA,2007,c.8,s. 19(1)].

Inspector ID #:	175

Additional Required Actions:
CO #004 –A Director's Order was served on the licensee. Refer to the "Order(s) of the Director" form.

WN #5: 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 subsections:
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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings:

1. Under Reg 79/10 s. 30 (1) 1. There must be a written description of the falls prevention and management 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 sources when required.

2.Review of the home's Policy for Bed and Assist Rails indicates:
Upon completion of an assessment which indicates that when both assist rails are applied for the safety of the resident, the Registered Staff shall develop a plan of care for the use of the rails, which includes the reason for their use.
...The Staff member raising the rails is to ensure that the rails are properly secured and that the call bell is placed within easy reach of the resident when side rails are in use.

3. Critical Incident Report was reviewed and indicated two assist/half rails rails were in use for resident #1.

4.Interview with a senior staff member confirmed the staff neglected to make sure the resident's nurse call bell pad was pinned or clipped to the resident when staff left the resident in the room the day of the Critical Incident. Interview with a second senior staff member confirmed resident#1's call bell clip was missing the date of the Critical Incident.

5.A review of resident #1's health record indicates there is no written assessment to identify the resident's need for 2 half assist rails placed on the lower half of the resident's bed and staff did not develop a plan of care, which included the reason for their use.

6.Review of Resident #1 nursing progress notes indicated staff did not comply with the home's Policy for Bed and Assist Rails on an identified date when a staff member entered resident #1's room and found that resident #1 fell/climbed out of bed. Both side rails were not in place as per note on bedroom wall. Outside rail not in place to help secure resident from climbing out of bed.

The licensee failed to ensure the home's Policy for Bed and Assist Rails was complied with.[Ref.r.8.(1)].

Inspector ID #:	175

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 the home's Policy for Bed and assist Rails is complied with, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**		**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Lynne Duchesne for amended
Title:	**Date:**	**Date of Report:** (if different from date(s) of inspection). Report Aug 15 '13

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**
Name of Director:	Mary Nestor
Order Type:	☐ Amend or Impose Conditions on Licence Order, section 104 ☐ Renovation of Municipal Home Order, section 135 ☒ Compliance Order, section 153 ☐ Work and Activity Order, section 154 ☐ Return of Funding Order, section 155 ☐ Mandatory Management Order, section 156 ☐ Revocation of Licence Order, section 157 ☐ Interim Manager Order, section 157
Intake Log # of original inspection (if applicable):	O-001423-12
Original Inspection #:	2012_048175_0011
Licensee:	The Corporation of the County of Northumberland
LTC Home:	Golden Plough Lodge
Name of Administrator:	Clare Briggs (Acting)

Background:	

During the inspection the Inspector found that the Licensee (The Corporation of the County of Northumberland (Golden Plough Lodge or the Licensee) failed to comply with the *Long-Term Care Homes Act, 2007* (LTCHA) s. 6(7) and as a result issued an Order pursuant to s. 153(1)(b) of the *Long-Term Care Homes Act, 2007* (LTCHA).

The Licensee submitted a request for a Director's Review of the Order. The original Order of the Inspector was substituted with this Director's Order.

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order:	#001

To The Corporation of the County of Northumberland, you are required to comply with the following order(s) by the date(s) set out below:

Pursuant to LTCHA 2007, S.O. 2007, c.8, section 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.

Order:

The Licensee shall prepare, submit and implement a plan to ensure that the care set out in the plan of care for each resident, including, but not limited to, all dependent residents identified at high risk for falls and the inability to speak, is provided to that resident. This plan should include a system to monitor that the care is being provided.

The plan is to be submitted to the Ottawa Service Area Office, 347 Preston St., 4th Floor, Ottawa ON K1S 3J4 by October 16th, 2012.

Grounds:

Evidence gathered by the Inspector from documentation reviews showed that Resident #1's plan of care addressed safety and care issues including:

- That the bed needed to be in the lowest position
- a functioning bed alarm was to be in place when the resident was in bed
- Need for a specific bedtime routine
- restless behaviour
- complications from a stroke (aphasic)
- at risk for falls
- multiple other risk factors.

The inspectors' evidence from interviews and Progress Notes shows that:

- Resident #1's bed was not always in its lowest position,
- there were continuing issues and confusion with the appropriate functioning of the bed alarms throughout the home,
- that Resident #1 did not have a functioning bed alarm despite the plan of care indicating that the

resident was to have one,

- that Resident #1 had a known and documented history of falls out of bed
- two of the staff (PSWs) who were on shift on a specified date in June 2012 in the evening and responsible for Resident #1's care, told the Inspector in their interviews, that they did not provide Resident #1 with the established evening routine immediately after putting the resident to bed after supper because they were providing care to other residents on the floor who required their attention and that they would return to Resident #1 later, and
- that three earlier incidents were very similar in their description in the Progress Notes to the incident in June 2012, which resulted in the resident's death.

Information supplied by the licensee and contained in the Gilmour Report (the report of an investigation by an external consultant hired by the Licensee) also confirms that:

- the bed was not at the lowest position,
- the bed alarm was not used for Resident #1 the evening the resident died nor for some time before,
- the two PSWs who were providing Resident #1 with care that evening confirmed that they put the resident to bed with the assistance of a Hoyer lift and intended to return later in the evening to complete the resident's evening care routine after taking care of other residents requiring assistance and particularly lifts into bed.
- "there was no documentation or direction to staff to discontinue Resident #1's bed alarm".

- The Licensee was aware that Resident #1 was at high risk of injury because of the well-documented history of climbing out of bed as well as the circumstances which contributed to this behaviour, as indicated in the plan of care. Yet, the key components of the plan of care which would mitigate the risk of Resident #1 climbing out of bed and falling out of bed were not followed and not provided.

This order must be complied with by:	October 31, 2012

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007.* If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

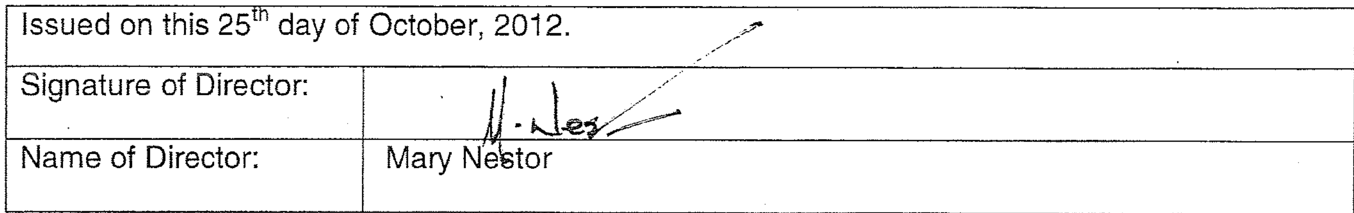
and the

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
1075 Bay St., 11th Floor, Suite 1100
Toronto ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité



Issued on this 25th day of October, 2012.	
Signature of Director:	
Name of Director:	Mary Nestor

Version date: May 29, 2012

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire X Public Copy/Copie Public
Name of Director:	Mary Nestor
Order Type:	☐ Amend or Impose Conditions on Licence Order, section 104 ☐ Renovation of Municipal Home Order, section 135 x Compliance Order, section 153 ☐ Work and Activity Order, section 154 ☐ Return of Funding Order, section 155 ☐ Mandatory Management Order, section 156 ☐ Revocation of Licence Order, section 157 ☐ Interim Manager Order, section 157
Intake Log # of original inspection (if applicable):	O-001423-12
Original Inspection #:	2012_048175_0011
Licensee:	The Corporation of the County of Northumberland
LTC Home:	Golden Plough Lodge
Name of Administrator:	Clare Briggs (Acting)

Background:	

During the inspection the Inspector found that the Licensee (The Corporation of the County of Northumberland (Golden Plough Lodge or the Licensee) failed to comply with the O. Reg 79/10 s. 48(1) and as a result issued an Order pursuant to s. 153(1)(a) of the *Long-Term Care Homes Act, 2007* (LTCHA).

The Licensee submitted a request for a Director's Review of the Order. The original Order of the Inspector was substituted with this Director's Order

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order:	#003

To The Corporation of the County of Northumberland, you are hereby required to comply with the following order(s) by the date(s) set out below:

Pursuant to O. Reg. 79/10, s. 48(1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.

Order:

The Licensee shall develop and implement a home specific, interdisciplinary falls prevention and management program which meets at least the minimum requirements set out in s. 49(1) and 49(2) of the Regulation, and in s. 30(1) of the Regulation; and, while work is on-going on the development of the program, the Licensee shall put a contingency plan in place to ensure that staff have complete and current information in respect of falls prevention and management available at all times.

Grounds:

- Falls Management Policies and Procedures for Registered Nursing Staff and PSWs were in various states of revision for 3 months and were stored on a shared office drive on the computer; PSW staff did not have access to the computer.
- The policies and procedures in place did not meet the minimum requirements of:
  - The falls prevention and management program specifically, provided for in s. 49 of the Regulation; and
  - General requirements provided for in s. 30 (1) for each of the interdisciplinary programs required under s. 48 of the Regulation
- The physiotherapy quarterly re-assessment dated in 2012 indicated that the resident risk of falls was

'not applicable' and not assessed. Physio. did not have the resident on a Falls Prevention Program despite the fact that Resident #1 experienced falls from the bed as documented in progress notes

- The physiotherapy assessment dated in 2012, indicated incorrectly that the resident fell 1 – 2 times in the last six months. Review of the Progress notes from Admission indicated resident #1 had fallen from the bed four times in six months.
- The physiotherapy assessment and re-assessment was based on incomplete or inaccurate information relating to risk of falls, and the number and types of falls from bed experienced by Resident #1 since admission; this in turn led to a missed opportunity to mitigate those risks and develop a comprehensive falls management and prevention program for Resident #1, with interdisciplinary input and collaboration.
- The ADOC indicated that there are no policies and procedures developed in the home related to the use of resident personal bed or chair alarms as a safety device to prevent falls or guidelines for staff to follow if the alarms are malfunctioning.
- The evidence shows that there is a lack of a well-developed, interdisciplinary and easily accessible Falls Prevention and Management Program in the home.
- The contents of the policies and procedures are sparse and not well-developed, and do not address the key components of an effective and comprehensive, interdisciplinary falls prevention and management program.
- References to procedures are vague and high-level, describing generalities rather than providing the staff with detailed processes to guide an interdisciplinary assessment, care plan development and care provision (such as screening protocols, clinically appropriate assessment and reassessment instruments), to support residents to achieve optimum functioning and prevent injury.
-

This order must be complied with by:	October 31, 2012

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

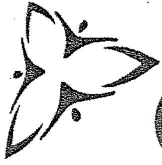
The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007.* If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
1075 Bay St., 11th Floor, Suite 1100
Toronto ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.



Issued on this 25th day of October, 2012	
Signature of Director:	
Name of Director:	Mary Nestor

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire X Public Copy/Copie Public
Name of Director:	Mary Nestor
Order Type:	☐ Amend or Impose Conditions on Licence Order, section 104 ☐ Renovation of Municipal Home Order, section 135 x Compliance Order, section 153 ☐ Work and Activity Order, section 154 ☐ Return of Funding Order, section 155 ☐ Mandatory Management Order, section 156 ☐ Revocation of Licence Order, section 157 ☐ Interim Manager Order, section 157
Intake Log # of original inspection (if applicable):	O-001423-12
Original Inspection #:	2012_048175_0011
Licensee:	The Corporation of the County of Northumberland
LTC Home:	Golden Plough Lodge
Name of Administrator:	Clare Briggs (Acting)

Background:	

During the inspection the Inspector found that the Licensee (The Corporation of the County of Northumberland (Golden Plough Lodge or the Licensee) failed to comply with the *Long-Term Care Homes Act, 2007* (LTCHA) s. 19(1) and as a result issued an Order pursuant to s. 153(1)(b) of the *Long-Term Care Homes Act, 2007* (LTCHA).

The Licensee submitted a request for a Director's Review of the Order. The original Order of the Inspector was substituted with the Director's Order.

Order:	#004

To The Corporation of the County of Northumberland, you are hereby required to comply with the following order(s) by the date(s) set out below:

Pursuant to LTCHA, 2007 S.O. 2007, c.8, section 19.(1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Order:

The Licensee shall prepare, submit and implement a plan to ensure that s. 19 is complied with and that all residents in the home are not neglected by the licensee and staff of the home. In particular, the plan shall include, but not be limited to the implementation of an effective interdisciplinary falls prevention and management program.

The plan is to be submitted to the Ottawa Service Area Office, 347 Preston St., 4th Floor, Ottawa ON K1S 3J4 by October 16th, 2012.

Grounds:

- Resident #1 was admitted to the home in 2011, with complications from a stroke.
- Resident #1 was "at risk for falls; interventions on the resident's care plan included that staff will ensure the bed alarm is functioning properly".
- There were a number of incidents in 2011and 2012 documented in Progress Notes all describing similar circumstances involving Resident #1 climbing out of bed or falling out of bed, found half-way or fully out of bed:
- "There was no nursing documentation indicating the registered nursing staff acted to ensure the resident's personal alarm was functioning".
- There was no documentation or staff report of any action taken by staff to communicate the malfunctioning alarm in the Maintenance Book, or to ensure that the resident had a functioning safety device.
- Resident #1's care plan indicates the resident is not toileted and at times "becomes restless, moves to the end of the bed to get up".
- After the fifth fall in 2012, a staff member reported the resident was incontinent when put to bed and was not changed. Interventions to manage the resident's incontinence to minimize the risk of the resident climbing out of bed were not effective in prevention of falls and registered nursing staff neglected to re-assess the resident's continence needs.

- PSW staff neglected to change Resident #1 when they put the resident to bed, although it was reported that it was known that the resident was wet and the resident being wet increased the risk of the resident climbing/falling from bed.
- The resident fell out of bed on a specified date in June 2012, and the fall was implicated in the resident's death.
- Registered nursing staff documented in 3 out of 4 resident falls prior to the spring of 2012, factors contributing to high falls risk and neglected to take action to minimize or reduce the risk to Resident #1.
- Physiotherapy staff neglected to correctly assess Resident #1's risk for falls, to monitor the incidence of falls...and to initiative a falls prevention program.
- Resident #1's bed rails, as noted in the resident's health record, were reported to be half rails, one on either side on the bottom half of the bed, which were not effective care interventions to manage the resident's high risk for falls.
- Registered staff "neglected to follow" the home's policy on Bed and Assist Rails, and "neglected to develop a plan of care for the use of assist rails, which includes the reason for their use. Specific directions were not provided for staff related to the use of side rails/assist rails.
- Registered nursing staff repeatedly neglected to re-assess the falls risk for Resident #1 after each of the four falls in which the resident feel diagonally, head-down.
- An interview with the DOC in June 2012, "confirmed there was no review/investigation of Resident #1's health record, post fall resulting in death, as part of the follow-up analysis to identify immediate corrective actions to prevent recurrence".
- Interviews with the Administrator in June 2012, "confirmed that there is no facility specific, interdisciplinary process in place to guide the management of Critical Incidents involving residents".
- A Memo to staff about ensuring all residents have access to call bells was posted days after the Critical Incident.
- The DOC reported that the staff did not have the call bell pad pinned or clipped to the resident and days after the death of the resident the DOC reported she did not know why the resident did not have a personal alarm.
- The pattern of incidents starting in 2011, less than a month after Resident #1 was admitted to the home and up to the date of their death in the June of 2012, in circumstances very similar to previous incidents, required a co-ordinated, interdisciplinary examination and response – none of which occurred as evidenced by Progress Notes, the resident's plan of care as well as documentation on the Physiotherapy Assessment and Re-Assessment.

This order must be complied with by:	October 15, 2012

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007.* If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
1075 Bay St., 11th Floor, Suite 1100
Toronto ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Issued on this 25th day of October, 2012.	
Signature of Director:	[signature]
Name of Director:	Mary Nestor

Version date: May 29, 2012

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**
Name of Director:	Mary Nestor
Order Type:	☐ Amend or Impose Conditions on Licence Order, section 104 ☐ Renovation of Municipal Home Order, section 135 ☒ Compliance Order, section 153 ☐ Work and Activity Order, section 154 ☐ Return of Funding Order, section 155 ☐ Mandatory Management Order, section 156 ☐ Revocation of Licence Order, section 157 ☐ Interim Manager Order, section 157
Intake Log # of original inspection (if applicable):	O-001423-12
Original Inspection #:	2012_048175_0011
Licensee:	The Corporation of the County of Northumberland
LTC Home:	Golden Plough Lodge
Name of Administrator:	Clare Briggs (Acting)

Background:	

During the inspection the Inspector found that the Licensee (The Corporation of the County of Northumberland (Golden Plough Lodge or the Licensee) failed to comply with the *Long-Term Care Homes Act, 2007* (LTCHA) s. 6(10) and as a result issued an Order pursuant to s. 153(1)(a) of the *Long-Term Care Homes Act, 2007* (LTCHA).

The Licensee submitted a request for a Director's Review of the Order. The original Order of the Inspector was altered and substituted with the Director's Order.

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order:	#005

To The Corporation of the County of Northumberland, you are hereby required to comply with the following order(s) by the date(s) set out below:

Pursuant to LTCHA 2007, S.O. 2007, c.8, section 6(1):

Plan of care

6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(a) the planned care for the resident;

(b) the goals the care is intended to achieve; and

(c) clear directions to staff and others who provide direct care to the resident.

Order:

The Licensee shall review and update as required the plans of care for each resident assessed as being at risk of falls to ensure that the written plan of care sets out clear directions for staff and others who provide direct care. At a minimum, plans of care must identify the applicable components of the falls prevention and management program and the requirements for the use of equipment, supplies, devices or assistive aids specific to the residents' needs and provide clear direction in respect of the use of the equipment, supplies, devices or assistive aids.

Grounds:

- A review of the Health Care Record including the Care Plan for Resident #1, indicates the resident had a high risk for falls, and exhibited right sided weakness, an inability to speak due to a previous stroke.
- An interview with the ADOC on a specified date in June 2012 confirmed the written need for side rails or any safety device "should be documented in the care plan".
- There were no clear directions to staff regarding a call bell for Resident #1 and/or the use of side rail/assist rails.
- Interviews with two PSWs on a specified date in June 2012 indicated that the "grey call pad" had to be on Resident #1's shoulder, side rails/half rails were always in use.
- An interview with a third PSW on a specified date in June 2012 indicated that Resident #1 could not yell. It was further reported by the same PSW that she "could not remember" giving Resident #1 "the call bell on the bed the evening of their death".
- An interview with an RPN on a specified date in June 2012 indicated that side rails, half rails were always in use for Resident #1.

- An interview with the DOC on a specified date in June 2012 indicated that the staff did not pin or clip on the Resident's call bell.
- An interview with the Administrator on a specified date in June 2012 indicated that they understood "the call bell clip was missing" for Resident #1 on the day of their death.
- The Critical Incident Report submitted by the home on a specified date in June 2012, following the unexpected death of Resident #1, indicates that the resident's lower body was supported by a raised side rail. Staff indicated that Resident #1's "lower body was caught against the side rails and the remainder of the body was over the side of the bed".
- A review of the Plan of Care shows no reference or direction to staff on the use of side rails on Resident #1's bed safety, risk management or falls management.
- A Review of the Physiotherapy Assessment and Re-assessment shows no reference to side rails use on Resident #1's bed for safety, risk management or falls prevention and management.
- Key aspects of Resident #1's care and safety needs were not clearly communicated and did not provide clear direction to staff providing care, namely: use of a call bell for Resident #1, the use of bed side rail/assist rails, interventions and a program for falls prevention and management.
- Interviews with staff demonstrated confusion and lack of clarity in the use of and implementation of interventions such as bed rails and the call bell.

This order must be complied with by:	August 31, 2012

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

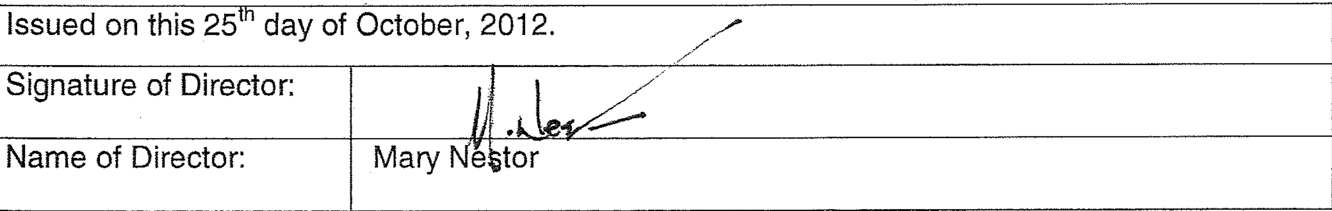
The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007.* If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
1075 Bay St., 11th Floor, Suite 1100
Toronto ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.



Issued on this 25th day of October, 2012.	
Signature of Director:	
Name of Director:	Mary Nestor

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Version date: May 29, 2012

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public
Name of Director:	Mary Nestor
Order Type:	☐ Amend or Impose Conditions on Licence Order, section 104 ☐ Renovation of Municipal Home Order, section 135 ☒ Compliance Order, section 153 ☐ Work and Activity Order, section 154 ☐ Return of Funding Order, section 155 ☐ Mandatory Management Order, section 156 ☐ Revocation of Licence Order, section 157 ☐ Interim Manager Order, section 157
Intake Log # of original inspection (if applicable):	O-001423-12
Original Inspection #:	2012_048175_0011
Licensee:	The Corporation of the County of Northumberland
LTC Home:	Golden Plough Lodge
Name of Administrator:	Clare Briggs (Acting)

Background:	

During the inspection the Inspector found that the Licensee (The Corporation of the County of Northumberland (Golden Plough Lodge or the Licensee) failed to comply with the *Long-Term Care Homes Act, 2007* (LTCHA) s. 6(10) and as a result issued an Order pursuant to s. 153(1)(a) of the *Long-Term Care Homes Act, 2007* (LTCHA).

The Licensee submitted a request for a Director's Review of the Order. The original Order of the Inspector was altered and substituted with the Director's Order.

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order:	#006

To The Corporation of the County of Northumberland, you are hereby required to comply with the following order(s) by the date(s) set out below:

Pursuant to LTCHA 2007, S.O. 2007, c.8, section 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;

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

(c) care set out in the plan has not been effective.

Order:

The Licensee shall review the plans of care for all residents assessed as being at risk of falls, consider whether the care set out in those plans of care to prevent falls is effective and, if not, re-assess the resident(s) and revise the plan(s) of care to address the ineffectiveness of the care for falls prevention.

Grounds:

- Resident #1"s health record, including Progress Note from a specified date in September 2011 to a specified date in April 2012 indicated a pattern of attempts to climb out of bed and falls from bed.
- The personal alarm care intervention was not effective in alerting staff of Resident #1's increased movement prior to experiencing a fall. Resident #1's needs related to high fall risk were not re-assessed and the care plan was not reviewed and revised when the resident's personal alarm was not effective.
- Interventions to manage the resident's incontinence to minimize the risk of the resident becoming we/restless and climbing out of bed were not effective in prevention of falls
- Nursing RAI MDS Quarterly Assessment dated April 2012, identified that Resident #1's urinary incontinence status had deteriorated and that the resident had fallen in the last 30-180 days. The resident's care plan was reviewed but not revised when the interventions to keep the resident feeling dry were ineffective.
- Progress Notes documenting incidents of Resident #1 climbing out of bed in November 2011, January 2012, and April 2012 indicated that no re-assessment of Resident #1's safety needs/half rail use completed.
- After the incident and death of Resident #1 on a specified date in June 2012, it was reported that the bed rails for the resident were half rails, one on either side of the bottom half of the bed and were not

effective care interventions to manage the resident's high risk for falls. There was no documentation or report of any re-assessment of the resident's safety needs related to the ongoing use of half rails.

- A review of the Plan of Care shows no reference or direction to staff on the use of side rails or half rails for Resident #1's bed safety, risk management or falls management.
- A Review of the Physiotherapy Assessment and Re-assessment shows no reference to side rails use for Resident #1's bed for safety, risk management or falls prevention and management.
- The Physiotherapy Assessment of a specific date in April 2012, indicated incorrectly that Resident #1 fell 1 to 2 times in the last six months – a review of the Progress Notes from the time of Resident #1's admission in August 2011 showed that the resident had fallen 4 times in 6 months.
- The RAI assessment on a specific date in January 2012 showed no re-assessment related to Resident #1's falls risk despite nursing Progress Notes after the incident in January involving a fall out of bed.
- An entry in April 2012 in the Progress Notes documented staff monitoring for the resident's health status however no re-assessment of Resident #1's falls risk was completed despite Resident #1's incident of that same day.
- A review of the RAP MDS Quarterly Assessment dated in April 2012 indicated "no falls since November 2011" – which was incorrect as Resident #1 had falls on January and April 2012.
- Key aspects of Resident #1's care and safety needs were not re-assessed when they were shown to be ineffective, specifically related to the use of personal alarm and bed alarm, Resident #1's deteriorating incontinence status, use of bed rails (half rails / side rails) and falls prevention and interventions.

This order must be complied with by:	August 31, 2012

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007.* If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

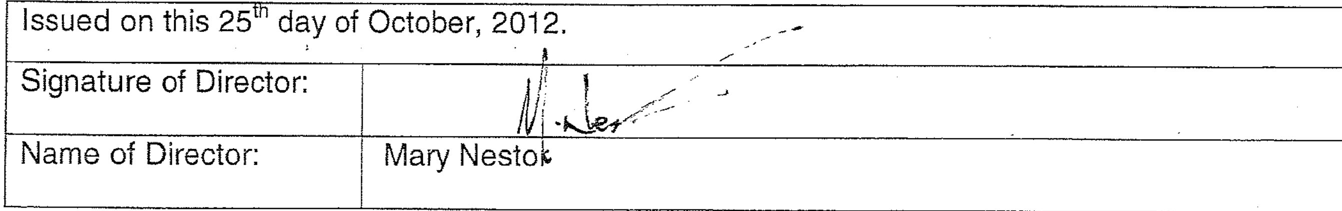
and the

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
1075 Bay St., 11th Floor, Suite 1100
Toronto ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité



Issued on this 25th day of October, 2012.	
Signature of Director:	
Name of Director:	Mary Nestor

Version date: May 29, 2012