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 # / Registre no	Type of Inspection / Genre d'inspection
Sep 27, 2016	2016_415190_0021	019160-16, 023817-16	Complaint

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF LAMBTON
789 Broadway Street WYOMING ON N0N 1T0

Long-Term Care Home/Foyer de soins de longue durée

MARSHALL GOWLAND MANOR
749 DEVINE STREET SARNIA ON N7T 1X3

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

SANDRA FYSH (190)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 24, 25 and 30, 2016

This complaint inspection related to resident care was a concurrent inspection that was conducted at the same time as the Resident Quality Inspection (RQI) but was not included in the RQI.
The following intakes were completed at the same time as the complaint and are included in this report:
023391-16 - M613-000021-16 related to resident care
031557-15 - M613-000027-15 related to resident care

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Resident Assessment Instrument Coordinator, Registered Nurse, Registered Practical Nurse, Personal Support Workers and resident.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Medication
Nutrition and Hydration
Recreation and Social Activities

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was followed.

During a morning medication pass, it was discovered that a medication was missing.

The medication record (E-mar) directed the Registered Staff to check the medication on each shift. The checks each shift were documented up to the shift when it was noted that the medication was missing.

Resident #001's plan of care provided a specific plan for administration of the medication.

The Director of Care and the Administrator stated that the plan of care was not followed as directed. [s. 6. (7)]

2. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

The plan of care for resident #001 outlined programs that were to be provided to the resident.

The resident was observed on several occasions, but no programs were being provided.

The Resident Assessment Instrument Coordinator (RAI-Coordinator) stated that the programs were usually provided by full time staff, but that staff had been on vacation.

The Administrator stated that the documentation for this resident was not completed by the part-time staff when the regular staff were on vacation. [s. 6. (9) 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 with ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 5th day of October, 2016

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

Original report signed by the inspector.