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 7, 2016	2016_415190_0020	025179-16	Resident Quality Inspection

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), ALISON FALKINGHAM (518), NEIL KIKUTA (658)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): August 22, 23, 24, 25, 26, 29, 30, 2016

The following intakes were completed within the RQI:

026322-15 - M613-000022-15 - Critical Incident related to alleged staff to resident abuse
028072-15 - M613-000024-15 - Critical Incident related to a fall

010511-16 - M613-000009-16 - Critical Incident related to alleged family to resident abuse
017713-16 - M613-000019-16 - Critical Incident related to a fall
020967-16 - M613-000015-16 - Critical Incident related to a fall
018291-16 - M613-000004-16 - Critical Incident related to a fall
018979-16 - M613-000007-16 - Critical Incident related to a fall
022788-16 - M613-000016-16 - Critical Incident related to a fall
022796-16 - M613-000013-16 - Critical Incident related to a fall
022932-16 - M613-000020-16 - Critical Incident related to resident care
023908-16 - M613-000023-16 - Critical Incident related to alleged family to resident abuse
025840-16 - M613-000024-15 - Critical Incident related to a fall

The following intakes were inspected at the same time as the RQI and can be found in separate reports:
031557-15 - M613-000027-15 - Critical Incident related to transferring and positioning
009998-16 - IL-43989-LO - Complaint related to resident care
019160-16 - IL-45038-LO - Complaint related to resident care
023391-16 - M613000021-16 - Critical Incident related to medication
023817-16 - IL-46054-LO - Complaint related to resident care

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Confidential Clerk, Dietary Manager, Dietitian, Housekeeping/Maintenance Supervisor, Registered Practical Nurse/Resident Assessment Instrument (RPN/RAI) Coordinator, Recreation Aide, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), resident and family members.

The inspectors also conducted a tour of all resident areas and common areas, observed residents and care provided to them, reviewed health care records and plans of care for identified residents, policies and procedures and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **3 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. (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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure there was a written plan of care for each resident that sets out the planned care for the resident.

On August 22, 23, and 24, 2016, resident #001 was observed in a tilt wheelchair.

On August 23, 2016, Personal Support Workers (PSW) #105 and #106 stated that resident #001 was tilted in a wheelchair because the resident was leaning forward and was at risk for falls.
On August 24, 2016, PSW #107 stated that resident #001 was tilted in a wheelchair for repositioning and comfort.
On August 24, 2016, Registered Practical Nurse (RPN) #113 stated that she did not know why resident #001 was tilted in a wheelchair.

A review of resident #001s' medical health records indicated no use of a tilt wheelchair.

Registered Nurse #100 stated on August 26, 2016, that resident #001 had a tilt wheelchair for comfort and repositioning, and that it should have been in the residents' plan of care.

The Administrator stated on August 26, 2016, that resident #001s' use of a tilt wheelchair should have been in the written plan of care. [s. 6. (1) (a)]

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 written plan of care for each resident sets out the planned care for the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that equipment, supplies, devices and assistive aids for the falls prevention and management program were readily available at the home.

On August 25, 2016, Personal Support Workers (PSW) #124, #125, and #126, and Registered Practical Nurse (RPN) #120 stated that resident #003 used a safety device when in bed, and a safety device when in a wheelchair.

Interview with the residents' Power of Attorney (POA) on August 25, 2016, indicated that a PSW had reported that the device was not functioning.

Documentation in progress notes stated that the safety device was not working properly. The POA was notified, and an email was sent to the Director of Care (DOC) and Resident Assessment Instrument (RAI) coordinator.

In a Point of Care (POC) task for PSWs to sign off on every shift. No checks were indicated in the "device not in functioning order" option.

Observation during the Resident Quality Inspection with RPN #120 indicated that the device was not working. RPN #120 stated that it should always be in place and working.

RN #111 stated that the device should be working at all times, and should have been replaced upon discovery. [s. 49. (3)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

s. 111. (1) Every licensee of a long-term care home shall ensure that a PASD used under section 33 of the Act to assist a resident with a routine activity of living is removed as soon as it is no longer required to provide such assistance, unless the resident requests that it be retained. O. Reg. 79/10, s. 111. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Personal Assistance Service Device (PASD) used to assist the resident with routine activity of living was removed as soon as it was no longer required to provide such assistance.

In resident #001s' medical chart, the consent to PASD form was signed for the use of a tabletop for "comfort, activity, eating, reading, to be removed when not in use."

Resident #001s' current plan of care indicated that the use of PASD tabletop was to assist with reading, eating, and activities when in a wheelchair. The PASD was to be removed when no longer required for the specific activity of living that it was in use to support.

Observation indicated that resident #001 was sitting in a wheelchair with a tabletop.

Interviews with Personal Support Workers (PSW) #105, #106, #107, recreation aide #112, and Registered Practical Nurse (RPN) #113 stated that the resident had the tabletop on at all times for safety, and activities.

RN #111 stated that staff were to follow the plan of care and remove the tabletop PASD when resident #001 no longer required it for assistance. [s. 111. (1)]

Issued on this 7th day of September, 2016

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

Original report signed by the inspector.