Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 13, 16, Aug 9, 2011	2011_089115_0003	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

TERRI DALY (115)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Resident Manager, one Registered Nurse and one Personal Support Worker.

During the course of the inspection, the inspector(s) reviewed the clinical record of one resident.

The following Inspection Protocols were used in part or in whole during this inspection:

Medication

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits sayants :

1. On June 13, 2011 at 12:26 p.m., during a review of a resident's medication MARS and progress notes from February to May 2011, records were found to be incomplete and not up to date. PRN effectiveness was not recorded for the following administered PRN medications.

On February 23, 2011 resident MARS indicate a PRN was given however no effectiveness recorded in the MAR and the progress notes are vague.
On February 28, 2011 resident MARS indicate a PRN was given however no effectiveness documented in the MAR or in progress notes.
On March 30, 2011 resident MARS indicate a PRN was given however no effectiveness recorded in the MAR or in progress notes.
On May 13, 2011 resident MARS indicate a PRN was given however no effectiveness recorded on MAR or in progress notes.
On May 19, 2011 resident MARS indicate a PRN was given however no effectiveness recorded on MAR or in progress notes.
On May 30, 2011 resident MARS indicate a PRN was given however no effectiveness recorded in the MAR or progress notes.

On June 13, 2011 at 12:22 p.m., during a discussion the homes Resident Manager indicated that the expectation for PRN medications is that the effectiveness is to be recorded on the back of the resident MAR.

WN #2: 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. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits sayants :

1. On June 13, 2011 at 1:44 p.m., a review of a resident's clinical records indicate that the resident's condition has deteriorated. However the most recent Quarterly Assessment does not reflect the residents current status and care regime.
An interview with a Personal Support Worker on the unit re: care level of the resident, the worker indicates that the resident has deteriorated, and that the residents needs change day to day.
2. On June 13, 2011 at 1:36 p.m., a review of the most recent Quarterly Assessment for the resident was found to be inconsistent with the resident's current status.
Cognitive pattern is identified as no change in cognitive status, however documentation indicates a recent change.
3. On June 13, 2011 at 1:31 p.m., a review of the Physician's notes indicate that the resident has had a change in condition, however the plan of care does not set out clear direction to staff or others who provide direct care to the resident in relation to individualized care requirements.

Issued on this 12th day of August, 2011

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