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
Oct 30, 2018	2018_563670_0026	010899-17, 014076-17, 020648-17, 027784-17, 027897-17, 028419-17, 001776-18, 002703-18, 004428-18, 006130-18, 008559-18, 008634-18, 008645-18, 011647-18, 016663-18, 018484-18, 020958-18, 024475-18	Critical Incident System

Licensee/Titulaire de permis

The 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

DEBRA CHURCHER (670), CASSANDRA TAYLOR (725), HELENE DESABRAIS (615), TERRI DALY (115)

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): October 22, 24, 25 and 26, 2018.

Inspector #721 was present for this inspection.

Log# 010899-17 Critical Incident System Report# M613-000016-17 related to a medication error resulting in transfer to hospital.
Log# 028419-17 Critical Incident System Report# M613-000050-17 related to a missing narcotic
Log# 011647-18 Critical Incident System Report# M613-000018-18 related to a missing narcotic.
Log# 002703-18 Critical Incident System Report# M613-000022-17 related to alleged family to resident abuse.
Log# 014076-17 Critical Incident System Report# M613-000020-17 related to alleged staff to resident abuse.
Log# 027897-17 Critical Incident System Report# M613-000047-17 related to alleged staff to resident abuse.
Log# 001776-18 Critical Incident System Report# M613-000004-18 related to alleged staff to resident abuse.
Log# 004428-18 Critical Incident System Report# M613-000007-18 related to alleged staff to resident abuse.
Log# 006130-18 Critical Incident System Report# M613-000008-18 related to alleged staff to resident abuse.
Log# 008645-18 Critical Incident System Report# M613-000012-18 related to alleged staff to resident abuse.
Log# 008559-18 Critical Incident System Report# M613-000013-18 related to alleged staff to resident abuse.
Log# 020648-17 Critical Incident System Report# M613-000028-17 related to a fall with injury.
Log# 027784-17 Critical Incident System Report# M613-000044-17 related to a fall with injury.
Log# 008634-18 Critical Incident System Report# M613-000011-18 related to a fall with injury.
Log# 016663-18 Critical Incident System Report# M613-000019-18 related to a fall with injury.
Log# 018484-18 Critical Incident System Report# M613-000021-18 related to a fall with injury.
Log# 020958-18 Critical Incident System Report# M613-000025-18 related to a fall

with injury.
Log# 024475-18 Critical Incident System Report# M613-000029-18 related to a fall with injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, four Registered Nurses, one Registered Nurse Behavior Supports Ontario, three Registered Practical Nurses, five Personal Support Workers, two Recreation and Leisure Attendants, the General Manager, one Housekeeping Aide and the Environmental Supervisor.

Inspectors also observed staff to resident interactions, provision of care, medication administration, dining observation, reviewed relevant clinical records and policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

For the purposes of the definition of physical and verbal in subsection 2 (1) of the Act,

"physical abuse" means, subject to subsection (2),
(a) the use of physical force by anyone other than a resident that causes physical injury or pain,
(b) administering or withholding a drug for an inappropriate purpose, or
(c) the use of physical force by a resident that causes physical injury to another resident;

"verbal abuse" means,
(a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident, or
(b) any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences. O. Reg. 79/10, s. 2 (1).

The home submitted a Critical Incident Systems report (CIS) on a specific date, and phoned the after-hours emergency pager on a specific date, to make a specific report.

Information contained within the CIS report stated that Personal Support Worker (PSW) #116 was accused of allegedly abusing six specific residents.

During a review of the homes internal investigation it was reported by PSW #120 and PSW #119 that they had individually witnessed PSW #116 commit specific acts.

On review of the specific six resident's clinical record it showed that the home had a physician come in to assess the residents. A specific resident was injured.

During an interview with the Administrator #100 it was confirmed that this incident met the definition of two specific types of abuse.

The licensee has failed to ensure that six specific resident's were protected from abuse by anyone.

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 residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, 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. The licensee has failed to ensure that there was a written policy that promoted zero tolerance of abuse and neglect of residents and that it was complied with.

The home submitted a Critical Incident Systems report (CIS) on a specific date, and phoned the after-hours emergency pager on a specific date, to make a specific report.

During a review of the homes internal investigation it was reported by PSW #120 and PSW #119 that they had individually witnessed PSW #116 commit specific acts.

During the review of the homes internal investigation it was observed that an incident had occurred with PSW #116 that prompted an investigation on a specific date. During this time the two PSW staff that worked closely with PSW #116 were unavailable for interview. The home met with PSW #120 and PSW # 119 on a specific date at which time PSW #120 and PSW #119 informed the home that on multiple occasions they had witnessed PSW #116 abuse residents.

During a review of the home's policy titled, Prevention of Abuse and Neglect to Residents, Policy: 2-8-18, Effective Date August 15, 2017. It states "3. Witnesses of any abuse of a resident will immediately intervene and remove the resident away from the situation and ensure they are safe. 4. Staff will notify their immediate supervisor or designate (other supervisor or charge nurse) immediately of any alleged, suspected or witnessed incidents of abuse.

During an interview with the General Manager (GM) #115 they confirmed that both PSW's #120 and #119 were aware of the incidents and did not report it to the home until questioned during an interview relating to a separate incident. The GM also confirmed that the PSW's did not follow the home's policy.

The licensee has failed to ensure that their written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

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 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a criminal reference check was conducted prior to hiring the staff member and/or accepted volunteer who was 18 years of age or older.

The home submitted a Critical Incident Systems report (CIS) on a specific date, and phoned the after-hours emergency pager to make a specific report.

Information contained within the CIS report stated that Personal Support Worker (PSW) #116 was accused of allegedly abusing six residents.

During an internal record review of employee files, it was observed that PSW #119 was hired on a specific date. PSW #119 began orientation with the home on a specific date which was 13 days after the hire date. On review of PSW #119's employee file it indicated that the criminal reference check was not completed until a specific date which was 27 days after the hire date and 14 days after the first day of orientation.

During an interview with the Administrator #100 if was confirmed the PSW #119 was hired on a specific date and received training on a specific date prior to receiving a clear criminal reference check.

The licensee has failed to ensure that a criminal reference check was conducted prior to hiring the staff member who was 18 years of age or older. [s. 75. (2)]

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 a criminal reference check was conducted prior to hiring the staff member and/or accepted volunteer who was 18 years of age or older, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

On a specific date, the home submitted a Critical Incident System report (CIS) related to a specific event that caused harm to a specific resident.

A review of the home's policy #4.12 "Medication Incidents" revised August 15, 2018, stated in part "Medication Administration Incidents: The administration/taking of a dose of medication to a resident for whom it is not prescribed".

A review of resident #006's progress notes in Point Click Care (PCC) on a specific date, stated that a Registered Practical Nurse (RPN) administered the wrong medication to resident #006 that caused a change in condition and resulted in a specific intervention needing to be utilized.

During interviews, RN #110 and RPN #108 stated that when the home has a student RPN or Registered Nurse (RN) they would expect that the preceptor, who was a RN or RPN, supervise the student when they administered medications to the residents.

During an interview, Administrator #100 stated that on the day of the incident, the RPN student's preceptor was supervised by RPN #108. Administrator #100 said that RPN #108 and the RPN student were doing two separate medication preparations for two different residents and at one point the RPN student left the cart and gave the wrong medication to resident #006.

The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensured that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident was immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that: resulted in a physical injury or pain to the resident, or caused distress to the resident that could have potentially be detrimental to the resident's health or well-being.

The home submitted a Critical Incident Systems report (CIS) on a specific date, and phoned the after-hours emergency pager on a specific date, to make a specific report.

Information contained within the CIS report stated that Personal Support Worker (PSW) #116 was accused of allegedly abusing six specific residents.

During a clinical record review of six specific resident charts it was observed that the home did not contact the SDM or person specified by the resident until the following day.

During an interview with General Manager (GM) #115 it was confirmed that there was no documentation of notification of the six specific residents families prior to a specific date.

During a review of the internal investigation an Electronic Mail (E-mail) message was observed. The message was between the Administrator #100 and GM #115 stating that families would be contacted the next day.

During an interview with Administrator #100 it was stated that the investigation had commenced at 1900 hours on a specific date, and confirmed the families of the six specific residents were not contacted until the next day.

The licensee has failed to ensured that six specific resident's decision maker and any other person specified by the resident was immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of that resident. [s. 97. (1) (a)]

Issued on this 30th day of October, 2018

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

Original report signed by the inspector.