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
Performance Improvement and Compliance Branch
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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
Sep 15, 16, 21, Oct 1, 17, 21, 2011	2011_088135_0014	Critical Incident

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

BONNIE MACDONALD (135)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Acting Resident Care Supervisor, Food Services Manager, 2 Registered Nurses, Confidential Support Services Clerk, 3 Health Care Aides and 1 Dietary Aide.

During the course of the inspection, the inspector(s) reviewed reports, policy and procedures, staff training records, resident's health records, observed dinner service and resident interactions in home area.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following subsections:

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).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. Sept. 15, 2011 17:57-in review of the home's policy Abuse to Residents, observed policy to promote zero tolerance of abuse and neglect of residents, does not contain an explanation of the duty under section 24 to make mandatory reports. Sept. 16, 2011 11:38-home's Support Services Clerk spoke with the home's administrator by phone and confirmed "mandatory reporting is not in our policy." [LTCHA, 2007 S.O. 2007, c.8,s 20.(2)(d)]

2. Sept. 15, 2011 17:57-in review of the home's policy Abuse to Residents, observed policy was not complied with for incident of resident to resident abuse as follows:
All management and registered staff that receive or have knowledge of an alleged suspected or witnessed incident of abuse shall investigate the incident using the investigation report form.

Sept. 16, 2011 10:38-in record review and interview with Acting Resident Care Supervisor, confirmed home's report form, had not been used in reporting incident of resident to resident abuse.
[LTCHA 2007 S.O. 2007, c.8 s.20 (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 ensuring written policy to promote zero tolerance of abuse and neglect of residents is complied with and shall contain an explanation of the duty under section 24 to make mandatory reports, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following subsections:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. Sept.15, 2011 15:05-in review of home's Critical Incident report sent to the Director, observed neither Physician or Registered Nurse in the Extended Class were contacted, when resident sustained an injury in incident of resident to resident abuse.

Sept.16, 2011 10:38-in record review and interview, home's Acting Resident Care Supervisor, confirmed neither Physician or Registered Nurse in the Extended Class were contacted, when resident sustained an injury.
[O.Reg 79/10, s. 104 3. ii]

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 ensuring a physician or registered nurse in the extended class be contacted in response to incident of abuse, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. Sept.15, 2011 18:43-in record review with Registered Nurse, observed resident had not been assessed, nor were their vital signs documented after injury in incident of resident to resident abuse. Home's policy requires residents be monitored and vitals be documented every half hour for the first four hours, every hour for the next 4 hours and every 2 hours for the next 4 hours.

Sept 16, 2011 11:09-in record review and interview, Acting Resident Care Supervisor confirmed resident was not monitored, nor where their vital signs documented according to home's policy, for injury resident sustained in resident to resident abuse.

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 ensuring any actions taken with respect to a resident under a program, including assessments,interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. Sept. 15, 2011 15:05-in review of home's Critical Incident
for abuse of a resident that resulted in harm; observed report was not submitted immediately to the Director of the Ministry of Health and Long-Term Care.

Sept. 16, 2011 10:55-in interview home's Acting Resident Care Supervisor, confirmed Ministry of Health and Long-Term Care had not been notified immediately. [LTCHA, 2007 S.O. 2007, c.8, s.24.(1) 2.]

Issued on this 21st day of October, 2011

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

Bonnie MacDonald