Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 25, 2020	2020_790730_0008	003783-20, 003892-20	Complaint

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

CHRISTINA LEGOUFFE (730), DEBRA CHURCHER (670), KRISTEN MURRAY (731)

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): March 10, 11, 12, and 13, and May 12, 13, 14, 15, 19, 20, and 21, 2020.

The purpose of this inspection was to inspect the following intakes:
-Critical Incident (CI) M613-000006-20/ Log #003783-20 related to Falls Prevention
-Complaint Log # IL- 75001-LO/ Log #003892-20 related to Falls Prevention, Medication Management, Nutrition and Hydration, and Personal Support Services

This inspection was completed concurrently with CIS inspection #2020_790730_0009.

During the course of the inspection, the inspector(s) spoke with Directors of Nursing and Personal Care (DONPCs), the Administrator, a Behaviour Support Ontario Registered Nurse (BSO RN), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and a Registered Dietitian (RD).

The inspector(s) also observed residents and the care provided to them, reviewed clinical records, and specific policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Nutrition and Hydration
Personal Support Services
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	Légende 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. (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 2007, c. 8, s. 6 (4).
(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).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved with the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

The Ministry of Long-Term Care (MLTC) received a complaint, which included concerns related to resident #001's oral care on a specified date. The complainant stated that they had concerns regarding resident #001's dental care.

A review of the current plan of care for resident #001 included a focus "ORAL/DENTAL CARE" and included a specified intervention, which was added to the plan of care on a specified date. The resident's plan of care did not include any interventions related to an identified dental care task.

Review of an assessment in Point Click Care (PCC) titled “Nutrition Assessment- V 2” for resident #001, on a specified date, indicated under section N. Dentition/Chewing/Swallowing that the resident had an identified dental device.

Review of an assessment in PCC titled “Dental Hygiene dental screening” for resident #001, on a specified date, indicated that resident #001 had an identified dental device.

During an interview Director of Nursing and Personal Care (DONPC) #104 said that staff would check a resident’s care plan to know if they had an identified dental device. They also said that resident #001 had an identified dental device upon admission to the home. They said that resident #001 required assistance morning and night related to oral/dental care and that resident #001’s plan of care did not provide clear direction for staff related to their oral care needs, as it did not identify that they had an identified dental device and required specified care.

The licensee has failed to ensure that staff and others involved with different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care for resident #001 related to oral care. [s. 6. (4) (b)]

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

The Ministry of Long-Term Care (MLTC) received a complaint, on a specified date, which included concerns related to resident #001’s bathing.

A review of resident #001’s plan of care in PCC included a focus related to bathing.

A review of the “Documentation Survey Report V-2” for specified dates, for resident #001, did not include documentation on two identified dates under the specified task related to bathing.

During an interview Registered Nurse (RN) #108 said that resident bathing was documented on Point of Care (POC) by Personal Support Workers (PSWs).

During an interview with PSW #107, they said that resident #001 had a history of refusing baths. They said that the procedure in the home was that if a resident refused a bath they would re-approach them later that day and then the following day.

During an interview Director of Nursing and Personal Care (DONPC) #104 said that if documentation was not completed then the care may not have been completed, but that sometimes the care was completed, but not documented. Regarding resident #001's baths on the identified dates, the DONPC said that by looking at the documentation on those dates it appears that resident #001 missed baths on those dates. They said that they would expect to see documentation in the progress notes if the resident had refused the baths and when they had re-approached.

The licensee has failed to ensure that resident #001's baths were documented. [s. 6. (9) 1.]

3. The licensee has failed to ensure that the plan of care was updated when the resident's care needs changed.

The Ministry of Long- Term Care (MLTC) received a Critical Incident Systems (CIS) report on a specified date related to a fall with hospital transfer for resident #001. The MLTC also received a complaint related to resident #001's fall, on a specified date.

During a review of the progress notes in Point Click Care (PCC), for resident #001, there was a progress note on a specified date, which stated that a specified intervention related to falls prevention was put in place for resident #001.

A review of the plan of care for resident #001 included a a specified intervention with created and initiated dates for the intervention later than what was specified in the progress notes. No interventions related to the specified intervention were found in the care plan dated prior to the specified date.

During an interview, Registered Nurse (RN) #102 said that a resident's care plan would indicate if they required the specified intervention.

During an interview, Personal Support Worker (PSW) #100 said that resident #001 had the specified intervention as one of their falls prevention measures, and that this intervention had been in place prior to their fall on the specified date.

During an interview Director of Nursing and Personal Care (DONPC) #104 said that staff would know if a resident required a specified intervention because it would be in their care plan. The DONPC said that the specified intervention was added as an intervention for resident #001 on a specified date but was not added to the written plan of care until a

later specified date. They said that they would expect that this intervention would have been added to resident #001's plan of care when it was initiated.

The licensee has failed to ensure that resident #001's plan of care was updated when they required a specified intervention related to falls prevention. [s. 6. (10) (b)]

Issued on this 27th day of May, 2020

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

Original report signed by the inspector.