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

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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
Feb 9, 2022	2022_974670_0003	019230-21, 019993-21, 000226-22, 000700-22, 001612-22	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)

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): February 1, 4, 7 and 8, 2022, onsite. February 2 and 3, 2022, offsite.

The purpose of this Inspection was to inspect the following:
Log# 000612-22 CIS# M613-000005-22 related to alleged resident to resident abuse.
Log# 019993-21 CIS# M613-000047-21 related to alleged resident to resident abuse.
Log# 019230-21 CIS# M613-000045-21 related to alleged resident to resident abuse.
Log# 000226-22 CIS# M613-000002-22 related to a fall with injury.
Log# 000700-22 CIS# M613-000003-22 related to a fall with injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, one Registered Nurse Infection Prevention and Control Lead, one Public Health Nurse, one Registered Nurse Behavioral Supports Ontario Lead, one Quality Improvement Manager, one Personal Support Worker Behavioral Supports Ontario, one Housekeeper, one Registered Practical Nurse Resident Assessment Instrument Coordinator, two Registered Practical Nurses, five Personal Support Workers and residents.

During the course of this inspection the Inspector observed the overall cleanliness and maintenance of the home, observed infection prevention and control practices in the home, observed staff to resident interactions, observed the provision of care, reviewed relevant clinical records and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

1 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	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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

O. Reg. 48 (1) 1. states: "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A falls prevention and management program to reduce the incidence of falls and the risk of injury."

The home's policy #35811 titled "Head Injury" stated, “To ensure that in all cases where there is an actual or suspected injury to the head and/or an unwitnessed fall, the head injury protocol will be followed.” The Registered Staff will assess the resident’s neuro-vital signs using the Head Injury record (for 72 hours post head injury)". Head Injury Record showed that a head injury routine (HIR), when required, should be completed post fall using the following time frames;
-every 15 minutes for four assessments.
-every 30 minutes for four assessments.
-every hour for five assessments.
-every four hours for four assessments.
-every eight hours for six assessments.

Review of resident #001’s clinical record showed that resident #001 had unwitnessed falls.

The Inspector was unable to locate any HIR assessments for 34 instances when a HIR would have been required.

During an interview with the Quality Improvement Manager (QIM) #106 resident #001's HIR records were reviewed and QIM #106 was also unable to locate HIR assessments for the 34 instances where a HIR would have been required. The QIM #106 acknowledged that there were multiple missing assessments, the timing on the assessments were often not put into the system or set up on the paper HIR correctly and were not always completed and should have been. The QIM #106 shared that they had recently implemented a new "docit" system for documenting HIR assessments and were experiencing some difficulties.

The homes failure to follow their Head Injury policy placed resident #001 at potential risk of unrecognized complication from a fall.

Sources: Resident #001 clinical record, the homes Policy #35811 Head Injury, the homes Head Injury Record and interview with QIM #106. [s. 8. (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 to ensure that, where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee shall ensure that the plan, policy, protocol, procedure, strategy or system, (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and (b) is complied with. O. Reg. 79/10, s. 8 (1), to be implemented voluntarily.

Issued on this 9th day of February, 2022

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

Original report signed by the inspector.