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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 19, 2014	2014_303563_0016	L-000639-14	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

MELANIE NORTHEY (563)

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): June 16, 2014

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

During the course of the inspection, the inspector(s) reviewed the home's investigation notes, made observations, reviewed health records, policies and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

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. 6. Plan of care

Specifically failed to comply with the following:

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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

Findings/Faits saillants :

1. The licensee failed to ensure the plan of care set out clear directions to staff and others who provide direct care to the resident.

Record review of resident # 001 PointClickCare care plan revealed several sections of the care plan had conflicting interventions and did not provide clear direction to staff.

The Administrator confirmed the plan of care for resident # 001 should be current and changes made to the care plan as they occur. [s. 6. (1) (c)]

2. The licensee failed to ensure that the outcomes of the care set out in the plan of care are documented.

Review in Point of Care (POC) regarding the documentation for Activities of Daily Living (ADLs) revealed the Personal Support Workers (PSWs) are only documenting under one question titled "AM/PM Care." This "AM/PM Care" question does not outline what ADL care was provided to the resident and the outcomes of that care.

Staff interview with PSW revealed he/she could not provide documented outcomes of the care provided to resident # 001. PSW shared the POC "AM/PM Care" question is answered once per shift for all residents in the home. PSW was not able to outline what ADL care was referenced under the "AM/PM Care" question in POC.

Observation of PSW documentation revealed the "AM/PM Care" question in POC stated, "1. Care completed by:" and the options were: Self, Staff, Care not provided at this time, Residents Bath Day, Resident Not Available, Resident Refused, and Not Applicable. This was the only ADL documentation for all AM/PM Care.

Staff interview with the Administrator revealed PSW staff were not documenting ADL outcomes in POC. The Administrator acknowledged that the "AM/PM Care" question it did not provide a mechanism to document outcomes of care. [s. 6. (9) 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 the plan of care set out clear directions to staff and others who provide direct care to the resident and that the outcomes of the care set out in the plan of care are documented, to be implemented voluntarily.

WN #2: 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 failed to ensure that any policy instituted or otherwise put in place is complied with.

Review of the policy demonstrated documentation was incomplete for resident # 001.

Staff interview with the Registered Nurse (RN) revealed it is the expectation that registered staff complete documentation in full.

The Administrator confirmed it is the home's expectation that the registered staff complete documentation at all times indicated as part of the policy protocol. [s. 8. (1) (a),s. 8. (1) (b)]

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 any policy instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: 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:

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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to immediately report the suspicion and the information upon which it is based to the Director regarding improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The PSWs immediately reported the incident to the Registered Practical Nurse who came and assessed resident # 001.

The Administrator confirmed that the critical incident should have been reported immediately. The Administrator confirmed this incident does fall under this legislation and was an oversight. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a care conference of the interdisciplinary team providing a resident's care is held at least annually to discuss the plan of care and any other matters of importance to the resident and their substitute decision-maker; and the resident and their substitute decision-maker are given an opportunity to participate fully in the conferences.

Interview with resident # 001 Power of Attorney for Personal Care (POA) revealed the POA does not recall ever being invited to or attending an annual conference with exception to the admission conference.

Record review of the Care Conference Minutes since admission revealed all annual care conferences were held without the resident or POA participation and there was no record of an annual care conference during one of the years since admission.

The Administrator shared that a letter is mailed to family 6 weeks in advance where by the family member is to RSVP to the registered nurse on the unit whether they will be attending or not. The Administrator could not confirm whether the POA received the letter, but shared it was given to the resident and mailed to the resident's POA. [s. 27. (1)]

Issued on this 23rd day of June, 2014

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