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

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 3, 2015	2015_349590_0006	L-001841-15	Resident Quality Inspection

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

ALICIA MARLATT (590), ALISON FALKINGHAM (518), NANCY SINCLAIR (537)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): February 9, 10, 11, 12, 13, 17, 18 and 19, 2015.

CI#M613-000002-15 was inspected during this RQI.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing and Personal Care, the Life Enrichment Supervisor, the Environmental Services Supervisor, the Dietary Supervisor, a Dietitian, a Dietary Aide, a Cook, a Maintenance staff member, a Pharmacist, a Quality Improvement Coordinator, a Housekeeper, the Residents Council President, the Family Council Acting President, nine Registered Nurses, four Registered Practical Nurses, four Personal Support Workers, 40+ Residents and five Family members.

During the course of the inspection, the inspector(s) toured all resident home areas, observed dining services, medication rooms, medication administration, the provision of resident care, recreational activities, resident/staff interactions, infection prevention and control practices and reviewed resident clinical records, posting of required information, meeting minutes relevant to the inspection and policies and procedures related to the inspection.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **5 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. 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).

Findings/Faits saillants :

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

Resident #9 is a high fall risk and has had multiple recent falls that were not witnessed by staff.
In the most recent fall risk assessment the resident was classified as a moderate fall risk.
The residents most recent care plan indicates a specific position for the bed to reduce the risk of falls.
The nursing communication board in the nursing office and three out of three staff members interviewed indicated that they keep this residents bed in a different position to reduce the risk of falls.
A registered staff member confirmed the care plan did not provide clear direction to the staff who provide direct care to the resident.
The Director of Nursing and Personal Care confirmed the expectation is that the plan of care is to provide staff with clear information and if the residents condition or care needs change it is to be reported to the registered staff and the care plan is to be updated. [s. 6. (1) (c)]

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 the plan of care sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's response to interventions are documented.

Record review for resident #1 reveals an area of altered skin integrity with a corresponding order for the following: Please document weekly under wound/ulcer progress note.

Review of the Home's policy 3-5-19-6 Skin and Wound Care indicates the following:
Residents with Pressure Ulcers - Registered Staff:
14. After a dressing change, complete the Pressure Ulcer/Wound Assessment Record (weekly) including size (circumference and depth) of a wound, discharge from the wound, appearance, progression, pain, nutrition, equipment being used, etc.

Review of the Residents clinical record identifies that the wound was signed off as being assessed with no corresponding supporting documentation in Point Click Care (PCC) notes.

A Registered Nurse acting for the Director of Nursing and Personal Care verified that there was no documentation on the identified date and that the expectation would be that there would be corresponding documentation in PCC outlining the results of the weekly wound assessment that had been signed off. [s. 30. (2)]

2. The licensee has failed to 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.

Resident #3 had an unwitnessed fall which resulted in an injury.
The resident confirmed that bruising developed in multiple places.

During observation of this resident during stage one of this Resident Quality Inspection, yellow-green bruising was noted to multiple places.
There is no documentation in the progress notes regarding this bruising.
The skin assessment completed by a registered staff member did not indicate that there was any bruising visualized.
This resident receives a bath twice weekly by a Personal Support Worker who is to document changes in skin integrity including bruising in Point of Care which should trigger an assessment by a registered staff member by appearing on the registered staffs computerized dashboard.
A registered staff member confirmed that there is no documentation of this bruising in any of the above mentioned documents.
The Director of Nursing and Personal Care confirmed that it is the expectation that bruising be documented on skin assessments or bath assessments and that this documentation is followed up by an assessment done by a registered staff member. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's response to interventions are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that foods and fluids are served at a temperature that is both safe and palatable to the residents.

During the initial Dining Observation on February 9, 2015 at the lunch meal served in Ivy Unit the temperature log was reviewed.
Temperatures at Point of Service were not taken or documented on:
February 1, 2015 lunch and dinner temps for all menu items
February 2, 2015 breakfast, lunch and dinner temps for all menu items
February 3, 2015 lunch menu items
February 4, 2015 lunch and dinner menu items
February 5, 2015 lunch and dinner menu items
February 6, 2015 breakfast and lunch menu items
February 7, 2015 dinner menu items

The cook confirmed that temperatures for all menu items at the point of service should be taken and documented prior to resident service.
Food Safety Policy Dietary 4-6-12 last reviewed October 2014 indicates:
Temperatures must be taken and recorded during production and at the point of service.
The Dietary Supervisor confirmed that the expectation is to take all food item temperatures during production and at the point of service and documented prior to serving these items to the residents to ensure that all foods and fluids are safe and palatable to the residents. [s. 73. (1) 6.]

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 foods and fluids are served at a temperature that is both safe and palatable to the residents, to be implemented voluntarily.

WN #4: 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 ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

An incident of staff to resident verbal abuse took place involving resident #20. Upon discovery of the incident an internal investigation was completed; however the home did not contact the residents SDM to notify them of the incident.
The homes policy titled "Prevention of Abuse and Neglect to Residents" (effective date is October 1978 and was last reviewed in July 2014, policy Index No:2-8-18) in the Procedure section 6 states that "The resident's family members, substitute decision makers, or others specified in the resident's plan of care will be notified immediately upon becoming aware of alleged, suspected or witnessed 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 health or well-being".
A Registered Nurse acting for the Director of Nursing and Personal Care confirmed that it is the homes expectation that all incidents of abuse are reported to the resident or SDM upon discovery.
The Confidential Services Clerk who spoke with the Administrator via telephone confirmed that resident #20's SDM had not been notified of the incident. [s. 97. (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 the resident's Substitute Decision Maker (SDM) and any other person specified by the resident are notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
4. Consent. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the documentation included consent for the use of the physical device to restrain.

Resident #7 uses a restraint for safety while up in her wheelchair. She was unable to release the restraint independently and required assistance from staff to remove it. Daily, she requests staff to apply this restraint as it makes her feel safe while up in her wheelchair.
The inspector was unable to locate a documented consent for the use of the restraint for resident #7.
A Registered Nurse acting for the Director of Nursing and Personal Care confirmed there was no documented consent for the use of the seat belt and further confirmed it is the homes expectation that consents are obtained and documented for the use of all restraints in the home. [s. 110. (7) 4.]

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 the documentation includes consent for the use of the physical device to restrain, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted: 11. Every resident has the right to:
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

The licensee has failed to ensure that every resident has the right to have his or her personal health information kept confidential.

Observation of a home area nursing station on Friday, February 6, 2015 revealed the nursing station door to the room where the resident health records are stored, was unlocked and unattended by a staff member. A Registered Practical Nurse confirms that it is the homes expectation that this door is to be closed when unattended by a staff member.

Observation of another home area nursing station on Wednesday, February 18, 2015 revealed the nursing station door to the room where the resident health records are stored, was unlocked and unattended by a staff member. A Registered Nurse confirms that it is the expectation that this door is to be closed when unattended by a staff member.

The Director of Nursing and Personal Care verifies that the personal health information of residents is to be kept confidential. [s. 3. (1) 11. iv.]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Resident #10 uses a personal assistive services device for positioning, comfort and to offload pressure.
Inspector was unable to locate a written or verbal consent from the resident or their SDM in the documentation for the use of this device.
The Director of Nursing and Personal Care confirmed there was no consent obtained prior to the use of the PASD. The Director of Nursing and Personal Care also confirmed it is the homes expectation that consents are to be obtained and documented for all restraints and PASD's used in the home. [s. 33. (4) 4.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all foods and fluids are prepared, stored, and served using methods which prevent adulteration, contamination and food borne illness.

During the dining observation on February 9, 2015 it was noted that all foods at the servery on Ivy Unit had their temperatures taken prior to serving with a thermometer and these temperatures were documented however the thermometer was cleaned by a dry cloth towel between each menu item.
This was confirmed by the cook.
The homes policy was reviewed and it indicated that the thermometers were to be cleaned with an alcohol wipe between each menu item. These alcohol wipes are kept in a drawer in each servery for the cooks convenience.
The Nutrition Supervisor confirmed the expectation is that the thermometer probe is to be cleaned with an alcohol wipe between menu items to prevent cross contamination of food items. [s. 72. (3) (b)]

Issued on this 3rd day of March, 2015

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

Original report signed by the inspector.