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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 30, 2018	2018_563670_0024	019966-17, 022688-17	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

DEBRA CHURCHER (670)

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): October 19, 22, 24 and 25, 2018.

Inspector #721 was present for this inspection.

The following intakes were inspected within this inspection:

Log# 022688-17 Complaint #OCMS HLTC2966MC-2017-7936 related to alleged resident to resident sexual abuse.
Log# 019966-17 Critical Incident System Report # M613-000027-17 related to alleged resident to resident sexual abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, one Registered Nurse, one Registered Nurse Behavior Supports Ontario, three Personal Support Workers, one Recreation and Leisure Attendant, one Housekeeping Aide, one Nursing Clerk, two Family Members, one Member of Parliament Assistant and two residents

During the course of this inspection the inspectors observed staff to resident interactions and provision of care, reviewed relevant policies and procedures and reviewed relevant clinical records.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **2 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	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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

On a specific date the home submitted a Critical Incident System report (CIS) to the Ministry of Health and Long-Term Care related to a specific incident. On a specific date the Ministry of Health and Long-Term Care received a letter of complaint from a specific person alleging a specific event occurred.

Review of resident #001 and #002's clinical records showed that an incident occurred between the two residents.

Review of a specific resident's care plan updated on a specific date, stated specific interventions were to be provided at specific intervals.

The home was unable to locate any documentation regarding the specific interventions for two specific months. Review of one specific month showed that for a total of 153 occasions there was no documentation of the specific intervention out of a required 512 occasions when documentation should have been completed.

Administrator #101 stated that there was missing documentation related to the specific intervention and that if it was not documented the intervention may not have been completed.

2. Resident #001's current care plan stated resident #001 was to have a specific intervention in place at all times.

Observation of resident #001's room on six separate occasions showed the intervention to not be in place on four out of the six observations. The specific resident was present in the room for all six observations.

Administrator #101 stated that the resident should have the specific intervention in place at all times if this was not being done the care plan was not being followed.

The licensee has failed to ensure that the care set out in the plan of care was provided to the specific resident as specified in the plan.

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence.

On a specific date the home submitted a Critical Incident System report (CIS) to the Ministry of Health and Long-Term Care related to a specific incident. On a specific date the Ministry of Health and Long-Term Care received a letter of complaint from a specific person alleging a specific event occurred.

Review of resident #001 and #002's clinical records showed that an incident occurred between the two residents.

Review of the home's internal investigation showed that the home had not notified the police on the date of the incident but had notified the police on a specific date due to a request from a specific person.

The home's policy, titled Prevention of Abuse and Neglect to Residents, effective date August 15, 2017, states the Administrator will notify the police of any alleged, suspected or witnessed incident of abuse or neglect of a resident that may constitute a criminal offence. Under the Abuse (reported and/or suspected)- Process Checklist, the policy stated Immediately; if this is a criminal act, call the Police.

Administrator #100 stated that when the incident was reported to them they did not think resident #002 had done anything and it did not occur to them that this incident would require the police. After reviewing the incident with a specific person the day after the incident they notified the police.

The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

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Issued on this 30th day of October, 2018

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

Original report signed by the inspector.