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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 6, 2019	2019_729615_0006	033573-18, 033745-18	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

HELENE DESABRAIS (615)

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): January 24, 25 and 28, 2019.

The following Critical Incidents (CI) report were inspected during this inspection:
CI #M613-000054-18/Log #033745-18 related to prevention of abuse and neglect;
CI #M613-000052-18/Log #033573-18 related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing and Personal Care, a Registered Nurse, a Social Worker and five Personal Support Worker.

During the course of the inspection, the inspector(s) also observed the resident home areas and common areas, observed residents' care provisions, resident/staff interactions, reviewed relevant resident clinical records, relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone

and free from neglect by the licensee or staff in the home.

On a specific date the home submitted Critical Incident (CI) #M613-000054-18/Log #033745-18 to the Ministry of Health and Long Term Care (MOHLTC) related to an incident that led a resident to a fall with sustained injuries.

A review of the CI indicated that the Director of Nursing and Personal Care (DONPC) and a maintenance staff viewed the recorded incident that occurred on a specific date and noticed a resident to resident altercation. One resident was found lying on the floor and was sent to the hospital with an injury.

Ontario Regulations 79/10, s. 5. defines “neglect” as “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents”.

A review of the home's policy #3-5-26 "Responsive Behaviours" last reviewed February 2017 stated in part "The home is committed to ensuring the needs of residents with responsive behaviours are met, while simultaneously protecting the safety of residents, staff and visitors. Understanding the sources/underlying causes of responsive behaviours is key to providing the optimal care for resident. When an individual's responsive behaviours escalate, this can lead to altercations among residents or staff and may be harmful or abusive. Therefore, a key aspect or resident care is to prevent or minimize the situations in which a resident exhibits responsive behaviours. Orientation and training: All direct care staff must receive training regarding Responsive Behaviours before providing care during orientation and annually thereafter".

A review of the resident involved's care plan before the incident indicated for interventions “Intervene as needed to protect the rights and safety of others".

A review of the recording of the incident on a specific date with the DONPC revealed the following:

- at a specific time a resident was knocking on the door of the nursing station that was closed;
- three minutes later the resident stopped knocking on the door and pushed another resident to the floor;
-few minutes later the resident was found on the floor by Personal Support Worker

(PSW) #103 and entered the nurses' station to warn the Registered Practical Nurse (RPN).
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The home's investigation included the following:

-An email sent to DONPC from a PSW stating in part that there was a previous incident involving the two residents resulting in injury and if the RPN would have answered the door, or intervened, this situation would have been different.
-A written statement of the RN stated in part that the resident told them that they pushed the other resident.
-A written statement of the DONPC stated in part that the Coroner classified the death a coroner's investigation due to the fracture because death would not have occurred if the resident weren't pushed.

During an interview, a PSW stated that the resident had responsive behaviours, was physically aggressive and that they would decrease if staff acknowledged them. The PSW added that on the day of the incident, they were hearing the resident banging on the nurses' station door and the RPN was in the nursing station. Then the banging went from the door to the glass window and that's when they left everything they were doing because the RPN was not intervening or opening the door. the PSW then walked towards the nurse's station and when they came around they saw the resident on the floor. The PSW added that the resident was expressing pain and the other resident acknowledged touching the resident. The PSW said that the resident knew they did something wrong and had lost their temper that night. The PSW stated that the RPN did not usually work in that unit and that they did not know the residents and they ignored the resident banging on the door.

During an interview, a PSW stated that on the day of the incident they were in the washroom near the nurses' station and could hear the two residents from the washroom and then heard a bang and the resident acknowledging that they touched the other resdient. The PSW added that they didn't work on that secured unit and didn't know what the resident's behaviours were.

During an interview, a Social Worker stated that they knew a few incidents where the resident was physically aggressive and that the resident was first on BSO internal caseload a few months ago after a physical altercation with that other resident. When asked if they thought staff working on a unit with residents with responsive behaviours should be trained for responsive behaviours, the social worker responded yes and that it

was something they were working as an ongoing training. They added that staff should also be aware of the care plan, and that it was all about being trained with GPA.

During an interview the DONPC stated that they, and the Administrator tested to see if someone could hear from where the RPN was sitting in the nurses' station if someone was knocking on the door and it was positive "you could hear the knocking on the door".

During an interview, the DONPC stated that the RPN was not trained for Gentle Persuasion Approach (GPA), that the only person that knew the residents on that secured unit was one PSW and the RPN and three other PSWs were from other units.

During an interview, the Administrator and the DONPC stated that when they saw the video of the incident they felt that the RPN did not intervene when the resident was presenting behaviours and knocking on the nursing door and that the incident could have been prevented. [s. 19. (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 residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

On a specific date the home submitted Critical Incident (CI) report #M613-000052-18/Log #033573-18 to the MOHLTC related to resident to resident physical abuse.

A review of the CI indicated that video recordings were viewed by the home and a resident was met by another resident in the hallway who struck them twice, causing them to fall to the ground and sustained an injury.

A review of the home's policy #3-5-26 "Responsive Behaviours" last reviewed February 2017 stated in part "Prevention: Identify the causes and triggers for responsive behaviours, altercations and harmful interactions. This assessment will include clinical assessments to ensure identification of causes of responsive behaviours. Develop strategies for prevention: Developing interventions to minimize triggers or respond effectively for specific residents and to prevent the escalation of potentially harmful or abusive situation. Plan of Care: Establish resident focused, interdisciplinary goals and strategies to ensure resident well-being and quality of life and resident/interdisciplinary team safety based on assessment findings".

A review of the home's investigation included notes written by Director of Nursing and Personal Care (DONPC) regarding the resident that since the incident the resident was showing physical aggression for a period of 24 days.

A review of the resident's Behaviour Care Path Assessment during that time, revealed in part:
RISK -Determine RISK of new or worsening behaviour/mood / delirium indicator(s):
Medium (risk of harm to self or others possible)
Specify: Has struck out at others twice as per NN.
CARE PLANNING
1a. Check each of the following boxes when complete. Items MUST be completed within 24hrs of opening Care path and ongoing as required*:
(The following were all checked)
a. Responsive Behaviour Focus added to Care plan
b. Care plan reflects presenting concerns
c. Care plan reflects potential risks
d. Care plan includes possible triggers to the Responsive Behaviours
e. Interventions to be implemented reflected in Care plan
f. POA particpated in action planning
Care Path Progress: Ongoing -assessment/ intervention required, Referral sent to Internal BSO Lead
Add Resident to BSO white board.

A review of the resident's Minimum Data Set (MDS) Quarterly review assessment during that time and under the Resident Assessment Protocols (RAPs), revealed:

"Behavioral Symptoms: Will be addressed in the care plan? Yes
This is a modified RAP. Changes were seen in the last quarter; therefore, changes have been made in his care plan to meet the new goal of maintenance through the next quarter".

A review of the resident's Behavioural Symptoms of Dementia Management full assessment during that time, indicated in part the following:

"Imminent Risk Identification: Physical aggression
Behaviours Documentation: Physical aggression, resistive behaviours, 2 incidents of aggression. Resistive to medications and care - for some staff".

A review of resident's current care plan initiated just after the incident had no mention of physical aggression for the resident.

Observation of the white board in the nursing station of the unit, showed the resident's initials and no mention of physical behaviours, triggers or interventions.

During interviews, a RN and a PSW both stated that the resident had responsive behaviours including physical aggression. The Inspector reviewed resident's care plan, kardex and white board with the RN and the PSW and they agreed that there were no mention of physical behaviours, triggers or interventions included and would expect this to be in the plan of care for the resident.

During an interview, the DONPC stated that the resident's physical behaviours would be expected to be addressed in the resident's plan of care. [s. 53. (4) (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 strategies are developed and implemented to respond to the resident demonstrating responsive behaviours, to be implemented voluntarily.

Issued on this 8th day of February, 2019

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

Original report signed by the inspector.