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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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 8, 2020	2020_777731_0007	002163-20, 003845-20	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

KRISTEN MURRAY (731), CHRISTINA LEGOUFFE (730)

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): March 10, 11, 12, and 13, and May 12, 13, 14, 15, 19, 20, 21, 25, 26, and 27, 2020.

The following Critical Incident System (CIS) intakes were completed within this inspection:

Critical Incident M613-000005-20 / Log #002163-20 related to Falls Prevention

Critical Incident M613-000007-20 / Log #003845-20 related to Prevention of Abuse and Neglect

This inspection was completed concurrently with Complaint Inspection #2020_790730_0008.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Directors of Nursing and Personal Care (DONPCs), a Behaviour Support Ontario Registered Nurse (BSO RN), Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs).

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **1 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 a resident was protected from abuse by anyone.

The home submitted Critical Incident System (CIS) report #M613-000007-20 to the Ministry of Long Term Care (MLTC) regarding an altercation of physical abuse involving resident #003 and resident #004, which resulted in resident #003 sustaining specified injuries.

Section 2(1) of Ontario Regulation 79/10 defines physical abuse as “(c) the use of physical force by a resident that causes physical injury to another resident”.

In a review of the CIS report submitted by the home, it identified that Registered Nurse (RN) #108 noted that resident #003 had specified injuries. The CIS report indicated that RN #108 reviewed the video surveillance, which identified a resident to resident physical altercation involving resident #003 and resident #004.

In a clinical record review of the progress notes for resident #003 and resident #004 it was identified through the video surveillance system reviewed by RN #108 that specified interactions and altercations occurred between resident #003 and resident #004 over a specified length of time. These interactions included multiple altercations of physical abuse by resident #004 toward resident #003.

In separate interviews with Personal Support Worker (PSW) #110 and RN #108, when asked if the home had a policy for the prevention of abuse and neglect, both staff members stated yes and indicated it was a zero-tolerance policy. When asked if RN #108 was familiar with the incident that occurred between resident #003 and resident #004, RN #108 stated yes, and that they were made aware of resident #003 having a specified injury at a specified time. RN #108 stated that they reviewed the resident’s notes to determine if there had been a fall or other incident and when unable to identify an incident, they further reviewed the video surveillance. Upon review of the video footage, RN #108 stated they observed the physical altercation towards resident #003 by resident #004 in a specified area of the home. RN #108 indicated they suspected there could have been further altercations that occurred outside of the video footage between resident #003 and resident #004. When asked if any staff members witnessed or heard the incident, RN #108 stated no.

A review of the home’s policy “Prevention of Abuse and Neglect”, number 2-8-18, last revised on July 3, 2019, stated “The Home’s Administrator is responsible for maintaining the dignity and safety of the residents. The Lambton County Homes have a zero-

tolerance policy for abuse and neglect. Abuse or neglect as defined by the Long-Term Care Homes Act, of any resident will neither be allowed nor condoned." The Policy further stated that it applied to all incidents of abuse of residents, regardless of who committed the abuse, including another resident.

The licensee failed to ensure that resident #003 was protected from abuse by resident #004. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 residents as specified in the plan.

The home submitted Critical Incident System (CIS) report #M613-000005-20 to the Ministry of Long Term Care (MLTC) regarding falls of resident#001 which resulted in a specified injury.

A) In a review of the home's policy titled "Falls Prevention and Management", number 3-5-6-0, effective May 12, 2017 and last revised February 5, 2020, the policy indicated one of the program objectives was to ensure individualized interventions for residents who had fallen.

In a review of the addendum to the Falls Prevention and Management policy titled "Falling Star Program for Residents at Risk for Falls", the policy stated the falling star logo was used by staff to quickly identify residents who are at risk for falling due to

frequent falls. The policy stated the locations of the logos included on the resident bulletin board and on the mobility aid.

In a clinical record review of resident #001's care plan, specified interventions were implemented related to falls prevention.

In multiple observations conducted by Inspector #731, resident #001 did not have the specified falls prevention interventions in place as outlined in their care plan.

In separate interviews with Personal Support Worker (PSW) #105 and Registered Practical Nurse (RPN) #104, when asked what interventions resident #001 had in place, both PSW #105 and RPN #104 stated resident #001 had specified falls prevention interventions that were to be in place.

In an interview with the Director of Nursing and Personal Care (DONPC) #106 when asked if the specified falls prevention interventions should have been in place for resident #001, DONPC #106 stated yes, because if it was care planned, it should have been used. [s. 6. (7)]

2. B) In a clinical record review of resident #002's care plan, specified falls prevention interventions were implemented.

In an observation conducted by Inspector #731, specified falls prevention interventions were not in place as outlined in their care plan.

In an interview with PSW #107, when asked if resident #002 was supposed to have specified falls prevention interventions in place, PSW #107 indicated yes. PSW #107 further looked in resident #002's room and confirmed that the specified falls prevention interventions were not in place.

The licensee failed to ensure that the falls prevention interventions set out in the plans of care were provided to resident #001 and #002 as specified in their plans. [s. 6. (7)]

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 residents as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

The home submitted Critical Incident System (CIS) report #M613-000005-20 to the Ministry of Long Term Care (MLTC) regarding falls of resident#001 which resulted in a specified injury.

In a review of the home’s policy titled "Falls Prevention and Management", number "3-5-6-0", effective May 12, 2017 and last revised February 5, 2020, the policy stated a fall is any unintentional change in position where the resident ends up on the floor, ground or other lower level. The policy further stated “when a resident has fallen, the Comprehensive Post Fall Assessment in PCC will be completed”.

In a clinical record review of resident #001’s progress notes, it was identified that resident #001 sustained falls on a specified date.

In a review of the assessments completed for resident #001, there was no documented post-fall assessment for one of the falls that occurred.

In separate interviews with Personal Support Worker (PSW) #105 and Registered Practical Nurse (RPN) #104, when asked if resident #001 sustained separate falls on the specified date, both PSW #105 and RPN #104 indicated yes. When asked whose responsibility it was to complete post-fall assessments, both PSW #105 and RPN #104 stated it was the registered staff member's responsibility to complete the post-fall assessment. When asked if a post fall assessment should have been completed for the fall, RPN #104 stated yes.

In an interview with the Director of Nursing and Personal Care (DONPC) #106 when asked about the post-fall assessments completed after a fall, DONPC #106 stated the registered staff completed the post-fall assessment in PointClickCare (PCC) after a resident had sustained a fall. When asked if resident #001 had multiple falls on the specified date, DONPC #106 indicated the notes suggested resident #001 sustained multiple falls on that day. When asked if there was a post-fall assessment completed for one of the falls, DONPC #106 indicated there was not a post fall assessment completed. When asked if the expectation in the home was that post-fall assessments should have been completed for each of the falls, DONPC #106 stated yes.

The licensee failed to ensure that when resident #001 had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (2)]

Issued on this 11th day of June, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KRISTEN MURRAY (731), CHRISTINA LEGOUFFE (730)
Inspection No. / No de l'inspection :	2020_777731_0007
Log No. / No de registre :	002163-20, 003845-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 8, 2020
Licensee / Titulaire de permis :	The Corporation of the County of Lambton 789 Broadway Street, WYOMING, ON, N0N-1T0
LTC Home / Foyer de SLD :	Marshall Gowland Manor 749 Devine Street, SARNIA, ON, N7T-1X3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Carla Alway

To The Corporation of the County of Lambton, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 19. (1) of the LTCHA.

Specifically the licensee must:
a) Ensure resident #003 and any other resident is protected from physical abuse by resident #004.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident was protected from abuse by anyone.

The home submitted Critical Incident System (CIS) report #M613-000007-20 to the Ministry of Long Term Care (MLTC) regarding an altercation of physical abuse involving resident #003 and resident #004, which resulted in resident #003 sustaining specified injuries.

Section 2(1) of Ontario Regulation 79/10 defines physical abuse as "(c) the use of physical force by a resident that causes physical injury to another resident".

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#003 and resident #004 over a specified length of time. These interactions included multiple altercations of physical abuse by resident #004 toward resident #003.

In separate interviews with Personal Support Worker (PSW) #110 and RN #108, when asked if the home had a policy for the prevention of abuse and neglect, both staff members stated yes and indicated it was a zero-tolerance policy. When asked if RN #108 was familiar with the incident that occurred between resident #003 and resident #004, RN #108 stated yes, and that they were made aware of resident #003 having a specified injury at a specified time. RN #108 stated that they reviewed the resident's notes to determine if there had been a fall or other incident and when unable to identify an incident, they further reviewed the video surveillance. Upon review of the video footage, RN #108 stated they observed the physical altercation towards resident #003 by resident #004 in a specified area of the home. RN #108 indicated they suspected there could have been further altercations that occurred outside of the video footage between resident #003 and resident #004. When asked if any staff members witnessed or heard the incident, RN #108 stated no.

A review of the home's policy "Prevention of Abuse and Neglect", number 2-8-18, last revised on July 3, 2019, stated "The Home's Administrator is responsible for maintaining the dignity and safety of the residents. The Lambton County Homes have a zero-tolerance policy for abuse and neglect. Abuse or neglect as defined by the Long-Term Care Homes Act, of any resident will neither be allowed nor condoned." The Policy further stated that it applied to all incidents of abuse of residents, regardless of who committed the abuse, including another resident.

The licensee failed to ensure that resident #003 was protected from abuse by resident #004.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it related to one resident reviewed. The home had a level 3 history as they had on-going non-compliance with this section of the LTCHA that included:

• Voluntary Plan of Correction (VPC) issued October 30, 2018

(2018_563670_0026);
• Voluntary Plan of Correction (VPC) issued February 6, 2019 (2019_729615_0006).
(731)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 27, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 8th day of June, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kristen Murray

Service Area Office /
Bureau régional de services : London Service Area Office