Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Aug 27, 2019	2019_559142_0021	011152-19, 012973-19, 013769-19, 014052-19	Complaint

Licensee/Titulaire de permis

MARIANHILL INC.
600 Cecelia Street PEMBROKE ON K8A 7Z3

Long-Term Care Home/Foyer de soins de longue durée

Marianhill Nursing Home
600 Cecelia Street PEMBROKE ON K8A 7Z3

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

JANET MCPARLAND (142)

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): July 18-19, 23-26, July 29-31, and August 1, 2019

This inspection included four complaint logs # 011152-19, 012973-19, 013769-19 and 014052-19 related to provision of care and services to residents.

During the course of the inspection, the inspector(s) spoke with residents and family members, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Dietary Aide, Environmental Services Aide, Activity Aide, the Environmental Services Manager, Unit Managers, the Director of Care (DOC) and the Administrator.
During the inspection, the Inspector also observed the provision of resident care and services and, reviewed resident health care records, bathing schedules, specific policies and procedures,staffing plans, schedules and staffing plan review minutes.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Nutrition and Hydration
Personal Support Services
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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 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 has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, the plan was complied with.
In accordance with O.Reg. 79/10 s.31(3) the licensee was required to ensure that the staffing plan (a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;

Specifically, the Licensee did not comply with the licensee's nursing staffing plan (revised date June 2019) which is part of the licensee's nursing and personal support services program.

The licensee's staffing plan was provided by the DOC to Inspector #142. Inspector #142 reviewed the PSW staffing plan with the DOC and is as follows:
B-wing (39 residents): Days-4 PSWs, Evenings-4 PSWs and Nights-1PSW
C-Wing (27 residents): Days- 3 PSWs, Evenings-3 PSWs and Nights- 1 PSW
D-Wing (34 residents): Days -3 PSWs, Evenings- 3 PSWs and Nights-1 PSW
2 D Wing (31 residents): Days-3 PSWs, Evenings-3 PSWs and Nights-1 PSW

During interviews with family members #130, 131, and 132, they indicated to Inspector #142 that over the past several weeks their family members (residents) have not received a tub bath or shower twice weekly due to lack of staff.

Inspector interviewed several staff members (PSWs and registered staff) and they indicated that tub baths and showers frequently need to be cancelled due to short staffing of PSWs. Staff further indicated that when the unit is not at the full compliment of PSWs that it is unsafe to have two PSWs in the tub room as it would leave no PSWs on the unit

to monitor other residents or to answer call bells.

During additional interviews, staff said that if a resident was not able to receive a tub bath or shower, they would be provided with a full sponge bath. Staff indicated that they would document that a bath was given, but the specific type of bath, such as a sponge bath, is not identified in the documentation. Therefore, staff said that if a resident received a sponge bath, it appears in the documentation that a resident received a bath, but it was not the bath of their choice. As well, some staff indicated that if a bath was not given they would document that 'activity did not occur' or 'not available'.

Between specific dates in July 2019, the Licensee implemented their resident heat risk assessment and management policy and procedure. In the procedure it indicated that for those residents at high risk for hot weather related illness, they would be offered an alternative to a tub bath as the rooms can exceed acceptable/tolerable temperature and humidity levels. In interviews with staff, they indicated that the alternative to a tub bath would be either a shower, if residents were able to have a shower, or full sponge bath.

Inspector #142 reviewed health records for residents #001, 002, 003, 006, 011, 013 regarding provision of baths. In a review of the plans of care for the identified residents, it was noted that each resident requested two baths or showers per week. Inspector #142 reviewed the bathing documentation records for documentation of 'activity did not occur' or 'not available' and the following was noted:
- Resident #001 did not receive a shower on identified dates.
- Resident #002 did not receive a tub bath on identified dates. Resident's heat risk assessment was completed and resident was identified at a specific risk level for hot weather related illness. During the home's implementation of the heat risk protocol, on resident's bath days on identified dates, staff documented 'not applicable'.
- Resident #003 did not receive a tub bath on a specific date. It was noted in resident #003 progress note of a specific date, that resident's tub bath was not completed due to insufficient staffing and time restraints.
- Resident #006 did not receive a tub bath on identified dates
- Resident #011 did not receive a tub bath or shower on identified dates
- Resident #013 did not receive tub bath or shower on identified dates

In review of the unit schedules it was noted that for the above identified dates in which residents did not receive their tub bath or shower, the resident home areas were not staffed as per the Licensees' staffing plan. The following are examples of staffing of PSWs according to the unit schedule provided to inspector by the DOC:

an identified date in June, 2019:
-B-wing: Days- 3 PSWs, evenings- 2.5 PSWs
-C-wing: Days-2 PSWs, evenings-2 PSWs
-D-wing- Days- 2.5 PSWs, evenings-2 PSWs
-2D wing-Days-2 PSWs, evenings-2 PSWs

an identified date in June, 2019:
-B-wing: Days- 3 PSWs, evenings- 3 PSWs
-C-wing: Days-2 PSWs, evenings-3 PSWs
-D-wing- Days- 2 PSWs, evenings-2 PSWs
-2D wing-Days-3 PSWs, evenings-1.5 PSWs

an identified date in July, 2019:
-B-wing: Days- 3 PSWs, evenings- 2 PSWs
-C-wing: Days-3 PSWs, evenings-2 PSWs
-D-wing- Days- 2.5 PSWs, evenings-2 PSWs
-2D wing-Days-2.5 PSWs, evenings-2.5 PSWs

In an interview with the DOC, they indicated that daily emails are sent out by schedulers to Managers and RNs so that they are aware of unfilled shifts. The DOC indicated that staff are offered overtime, staff are reallocated to assist with units not at full complement and other departments (such as recreation staff) assist on units with activities such as transporting of residents. The DOC and Administrator indicated that they reviewed the collective agreement and increased the hours they can schedule part-time employees which has had a impact on filling some of the shifts. As well, the Licensee established a support worker trial program. The DOC and Administrator further indicated that they continue to recruit additional PSWs, but the current shortage of PSW staff is making this difficult .
The Licensee did not comply with their nursing staffing plan resulting in residents #001, 002, 003, 006, 011, 013, not bathed, twice a week by the method of their choice. [s. 8. (1) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
11. Seasonal risk relating to hot weather. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The Licensee failed to ensure that plans of care for Residents # 001,003 and 004 were based on, at a minimum, interdisciplinary assessment of the residents' seasonal risk related to hot weather.

As per the Licensee policy "Resident Heat Risk Assessment and Management", a heat risk assessment is defined as a 'comparative risk of a resident acquiring a hot weather related illness." The policy further indicates that heat risk assessments will be completed on annual basis and when there is a change in resident health status.

Resident #003's heat risk assessment was completed on an identified date and resident was identified at a specific risk level for acquiring a hot weather related illness. On an identified date and time, the resident was exhibiting episodes of nausea and vomiting and elevated temperature and heart rate. Resident was re-assessed at an identified time and the resident reported feeling nauseated and had an episode of vomiting. It was noted in the progress notes that the resident's family placed fans in resident's room and cold cloths were applied to resident. It was further noted that resident was monitored during the night and had no further episodes of nausea or vomiting. On an identified date, resident was transferred to hospital for a change in condition. On an identified date, resident returned from hospital with a specific diagnosis.
In reviewing resident #003's plan of care, there was no indication that the seasonal risk relating to hot weather was identified and that interventions were planned. Furthermore, in review of resident #003's health record, there was no indication that a heat risk assessment was completed when resident #003 experienced a change in health status.

Resident #001's heat risk assessment was completed on an identified date and resident was identified at a specific risk level for acquiring a hot weather related illness. Resident #004's heat risk assessment was completed on an identified date and resident was identified at a specific risk level for acquiring a hot weather related illness. In review of the plans of care for resident #001 and #004, there was no indication that residents' seasonal risk relating to hot weather was identified and that interventions were planned.

In interviews conducted with RPNs #101,108,109,119,120,125, Unit Managers/RNs #123 and 124 and the DOC, they confirmed that the expectation is that when resident heat risk assessments are completed, interventions should be identified in the resident's plan of care.

In review of the current written plans of care for residents #001,003, and 004, the seasonal risk related to hot weather and interventions for the risk were not identified. Furthermore, resident #003's heat risk assessment was not completed when resident had a change in health status. [s. 26. (3) 11.]

Issued on this 27th day of August, 2019

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

Original report signed by the inspector.