Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
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Original Public Report

Report Issue Date: November 25, 2022

Inspection Number: 2022-1201-0001

Inspection Type:
Complaint
Critical Incident System

Licensee: Marianhill Inc.

Long Term Care Home and City: Marianhill Nursing Home, Pembroke

Lead Inspector	**Inspector Digital Signature**
Anandraj Natarajan (573)	Anandraj Natarajan Digitally signed by Anandraj Natarajan Date: 2022.11.25 12:32:42 -05'00'

Additional Inspector(s)
Sarah Bradshaw (740814)

INSPECTION SUMMARY

The Inspection occurred on the following date(s): October 11, 12, 13, 14, 17, 18, 19, 20, 21, 24, and 25, 2022.

The following intake(s) were inspected:

- Intake: #00001244- allegations of staff to resident neglect.
- Intake: #00001324- Fall of a resident resulting in an injury and transfer to the hospital.
- Intake: #00006641- Fall of a resident resulting in an injury and transfer to the hospital.
- Intake: #00009078- Fall of a resident resulting in an injury and transfer to the hospital.
- Intake: #00005901- Improper care resulted in risk of harm of a resident.
- Intake: #00001343- Complaint /concerns related to insufficient registered nursing staff.
- Intake: #00001728- Complaint /concerns related to insufficient nursing staff.
- Intake: #00006911- Complaint /concerns related to care and services to the resident

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The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management
Resident Care and Support Services
Safe and Secure Home
Staffing, Training and Care Standards
Medication Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

Rationale and Summary: The inspector observed the medication cart which was unlocked and unsupervised by the registered nursing staff. The unlocked medication cart was located outside the unit's dining area. Residents and visitors were observed passing by the medication cart. An RPN exited a resident room and approached the medication cart after approximately three to four minutes. The RPN indicated that they were responsible for keeping the medication cart locked when not in use. Failure to lock the medication cart posed potential risk, as medications were not secured and locked.

Sources: Inspector observation, and interview with the RPN. [573]

WRITTEN NOTIFICATION: Bathing

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)

The licensee failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Rationale and Summary: The Director (Ministry of Long -Term Care) received a complaint related to residents' baths were missed because the nursing staff were working short on the unit. The inspector reviewed a random selection of three residents' bath records for four identified months in 2022.

The plan of care for the identified three residents directed the staff to provide the residents bath twice a week. A record review of the three residents bathing records indicated that for the look back period a number of baths were not provided. The identified resident's health care records indicated that there was no documentation related to any behavioral concerns where staff would not be able to provide a bath. There was no documentation of missed baths being offered for an alternate day or any indication that these residents had refused.

During an interview, the unit manager indicated that when the staff were working short, the expectation was that if they were unable to get a scheduled bath or shower done for a resident, they would offer a bed bath or reschedule the bath or shower for an alternate day. After reviewing the identified residents bath record and progress notes, the unit manager was not able to give any reasons for the residents missed baths. Not ensuring that the residents were bathed at least twice a week may result in a negative impact to resident's health and quality of life.

Sources: The residents plan of care, progress notes, bath records, and interview with unit Manager. [573]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
1) Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the infection prevention and control (IPAC) standard issued by the Director was followed by staff related a) routine practices and additional precautions and b) hand hygiene program.

Rationale and Summary: The inspector observed a PSW with full Personal Protective Equipment (PPE) exited a resident's room with Droplet/Contact precautions. Upon exit, the PSW doffed their gown, gloves, changed their N95 mask to a surgical mask, performed hand hygiene and removed their eye protection. The inspector observed the PSW failed to follow the correct PPE doffing sequence after making direct contact with the resident on Droplet/Contact precautions.

The home's IPAC lead indicated to the inspector that the licensee's hand hygiene program was based on the Ontario Just Clean Your Hands (JCYH)– Long term Care program. During a lunch meal service, the inspector observed that the residents' hands were not cleaned before the meal service. During the same meal observation, the inspector observed an RPN not performing their hand hygiene between residents when completing the medication administration. The Ontario JCYH program requires that the staff assist residents to clean their hands before and after meals. The JCYH program places emphasis on staff on the essential moments for hand hygiene. Specifically, from one resident area to the next resident's area while providing care.

Sources: Observations and interview with the IPAC lead Nurse. [573]

2) Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The Licensee has failed to ensure any standard or protocol issued by the Director with respect to infection prevention and control is followed, specifically related to the use of personal protective equipment (PPE).

Rationale and Summary: A PSW was observed to be assisting a resident on contact/droplet precautions with their meal, without eye protection in place. The additional precautions signage posted outside of the resident room indicated that staff were required to wear full PPE including mask, eye protection, gown, and gloves for all resident interactions. The PSW confirmed with the inspector that eye protection should be worn and proceeded to don face shield eye protection. The inspector walked by the same resident room minutes later to observe the PSW had removed their face shield eye protection while standing next to the resident. At this time the PSW indicated that they had removed the face shield eye protection as they felt "claustrophobic" and preferred to use eye goggle as eye protection, but none were available on PPE cart outside of specific room.

A RPN observed without full PPE standing beside a resident of close contact sharing a room with resident on additional precautions. The RPN confirmed full PPE should be worn, exited room, and noted to be wearing a surgical mask over top of an N95 mask. The RPN proceeded to don PPE in incorrect sequence and no hand hygiene was observed before donning the PPE. Upon exiting the resident room the RPN doffed PPE incorrectly. The RPN was observed to remove eye protection and instead of sanitizing or discarding item, placed on ledge in hallway, removed and discarded gown, then gloves, continued to keep double mask on, and proceeded to walk down hallway.

Interview with the PSW and the RPN confirmed the need to use PPE when residents are identified to require additional precautionary measures when providing care. Interview with the DOC confirmed that staff should be wearing eye protection when caring for residents on contact/droplet precautions, that they should not be wearing double masks, and that staff should be following proper procedure for donning and doffing of PPE.

Failing to follow proper procedure with PPE related to the IPAC program, increases the risk of disease transmission among residents and staff, when a resident is identified to have additional precaution requirements related to IPAC.

Sources: Observations, and interviews with the PSW, RPN, and the Director of Care. [740814]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The Licensee has failed to 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.

Rationale and Summary: Resident #005 sustained a fall with an injury and was transferred to the hospital. A review of the clinical record indicated that a post fall assessment was not conducted using a clinically appropriate assessment instrument after resident #005's fall incident.

Resident #006 sustained a fall with an injury and was transferred to the hospital. The following day, the resident sustained another fall resulting in transfer to the hospital for further management. A review of the clinical record indicated that a post fall clinically appropriate assessment instrument was not conducted for the resident's two fall incidents.

Resident #007 had a fall and was later transferred to the hospital where the resident was diagnosed with an injury. On the previous day, the resident sustained a fall without injury. A review of the clinical record indicated that a post fall clinically appropriate assessment instrument was not conducted after the resident sustained two falls, within a 24-hour period.

Interview with the Director of Care confirmed that the post-fall assessment using a clinically appropriate assessment instrument was not completed for resident #005, resident #006 and resident #007's identified fall incidents. Failure to complete a post fall assessment increases the potential risk of harm to the resident. The use of the fall risk assessment instrument may have assisted staff to better identify the causes of the residents' fall, and thereby develop more effective fall prevention measures for the resident.

Sources: Critical incident reports, Residents' health care records, Interview with the Director of Care. [740814]