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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 5, 2012	2012_029134_0017	O-000033-12	Critical Incident System

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

COLETTE ASSELIN (134)

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): November 21 and 22, 2012

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Director of Human Resources and one Registered Practical Nurse (RPN).

During the course of the inspection, the inspector(s) reviewed Resident #1's Health Records, reviewed the Head Injury Assessment Policy # N023, the home's internal investigation file and the critical incident report

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The Licensee failed to comply with the LTCH Act 2007 c.8 section 6 (10) b, in that Resident #1 was not reassessed and the plan of care was not reviewed and revised when care needs changed after the resident sustained a head injury in January, 2012.

Resident # 1 had an un-witnessed fall in January, 2012.

The progress notes were reviewed. There is an entry indicating the resident complained of a headache, and sustained a hematoma with a small skin tear to the back of the head. [s. 6. (10) (b)]

2. After the fall, Resident # 1 was returned to bed. At the change of shift, the evening RPN reported to the oncoming night shift RPN, that Resident # 1's vitals were high but stable.

The Neurological Signs monitoring sheet was reviewed by the inspector. It was noted that Resident # 1's BP and Pulse were consistently higher than normal. The resident complained of a headache, had sustained a hematoma to the back of the head, had became agitated and had refused to open both eyes for the neurological assessment. The resident was not transferred to hospital and the physician was not notified.

Resident # 1's vital sign's electronic monitoring sheet, covering the last year, was reviewed. The documented blood pressure was noted to be in the lower range.

There is an entry in the progress notes indicating the resident had a second fall in the evening and was unable to weight bare as usual and needed to be lowered to the floor. The resident required assistance from 2 people to be returned to bed due to being unable to assist with the transfer.

There is an entry on the neurological sign monitoring sheet, which was completed after the incident, indicating Resident # 1 refused to open both eyes and was sleeping. As such the resident's level of consciousness was not evaluated as per policy, during the night shift following the head injury. The plan of care was not reviewed and revised. [s. 6. (10) (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 residents are reassessed and the plan of care reviewed and revised when residents' care needs change and in particular when a resident sustains a head injury, to be implemented voluntarily.

WN #2: 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 failed to comply with O. Reg 79/10 section 8 (1) in that the Head Injury Assessment Policy # N023 was not complied with as per requirement.

Resident # 1 was found on the floor in the hallway of the unit in January 2012. The resident had sustained a hematoma and a laceration to the back of the head.

The resident's neurological signs and levels of consciousness were monitored every 15 minutes for the first hour and every 30 minutes for the next 2 hours until 23:00. The BP and pulse were charted on the Neurological Signs worksheet. The resident had complained of a headache post fall and had a second fall later in the evening. The resident was unable to bare weight as usual and required assistance of 2 people to transfer back into bed. [s. 8. (1)]

2. The Licensee's Head Injury Assessment Policy # N023 specifies that the neurological assessment is to be conducted following a head trauma to determine the quality of the blood pressure, pulse and respiration. These are to be assessed and documented in the clinical notes. Drawing the size of the pupils to determine pupil size and level of consciousness is also to be documented. However on the night shift following the head injury, Resident # 1's neurological assessment was not completed every two hours. There is an entry on the neurological sheet indicating that Resident # 1 refused to open both eyes, at 23:30. There is an entry indicating Resident # 1 was sleeping. The resident's level of consciousness and pupil sizes were not monitored during the night shift.

Resident #1 was found unresponsive in the morning and was sent to hospital. The death certificate specifies that the resident died of hemorrhage secondary to a fall. [s. 8. (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 the head injury assessment policy N023 and the neurological sign monitoring sheet are reviewed and revised and complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

1. The Licensee failed to comply with the O. Reg 79/10 s. 107 (5) to promptly notify the Substitute Decision Maker (SDM) of a serious injury of Resident # 1.

Resident # 1 had an un-witnessed fall in the hallway on January 2012. The resident had sustained a hematoma and a skin tear to the back of the head. The Blood Pressure and Pulse, monitored every 15 minutes for the first hour and every 30 minutes for the next 2 hours, were observed to be consistently above normal and the resident was complaining of headache.

Later in the evening Resident #1 attempted to get out of bed and unable to weight bare as usual. The resident required the assistance of 2 people to be returned to bed. [s. 107. (5)]

2. The RPN working the night shift following the fall was interviewed by the inspector. It was reported that in the early part of the night shift Resident # 1 was complaining of a headache and was agitated. The resident's pulse and the diastolic pressure were high at change of shift. The RPN indicated that the hematoma had decreased in size and that since the resident refused to open both eyes, it was decided that the resident would not be awakened. Subsequently the resident's level of consciousness and vital signs were not monitored, which is contrary to the Licensee's Head Injury Assessment Policy N023.

The SDM was notified in the morning when Resident # 1's condition worsened and required to be transferred to the hospital for assessment.

In the circumstances of the symptoms Resident # 1 was showing, the head injury amounted to be a serious injury and the SDM should have been notified earlier. [s. 107. (5)]

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' SDMs are promptly notified of serious injury or serious illness of residents, in accordance with any instructions provided by the person who is identified, to be implemented voluntarily.

Issued on this 5th day of December, 2012

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Colette Asselin, LTCH Inspector #134