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

Division de la responsabilisation et de la performance du système de santé
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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_0019	O-002099-12	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
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, 22 and offsite November 23, 2012

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Nurse Manager, several Personal Support Workers.

During the course of the inspection, the inspector(s) reviewed Resident # 2's Health Records and reviewed the Licensee's Mouth Care Policy # C004.

The following Inspection Protocols were used during this inspection:
Personal Support Services

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 34. Oral care
Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee failed to comply with the O. Reg. 79/10 section 34 (1) (a) in that, Resident # 2 did not receive mouth care twice a day, for three consecutive days in September 2012.

The critical incident submitted in September, 2012 was reviewed. The home had reported that Resident # 2 was transferred to hospital for assessment due to respiratory difficulties. An X-Ray revealed that the resident's bottom partial dental plate was lodged in the resident's throat.

Resident #2's progress notes were reviewed and there is a chart entry made on a day shift in September 2012, indicating "Resident was noted to be coughing up copious amounts of phlegm this shift". Later, that evening there is an entry indicating the resident continues to cough up large amounts of phlegm.

The Inspector interviewed the Nurse Manager on November 23, 2012. The Nurse Manager indicated that during the investigation every PSW interviewed, was well aware of Resident # 2's mouth care needs and routine; that everyone indicated that the resident's upper denture and partial lower plate were to be removed at bedtime for soaking and were to be rinsed and inserted in the resident's mouth prior to breakfast. The Nurse Manager indicated that on the day where the resident became ill with a respiratory event, the PSW assigned to Resident #2 had inserted both dental plates during the morning mouth care and that in the afternoon, the same PSW had noticed the resident coughing up copious amounts of phlegm. This PSW had provided mouth care by getting the resident to rinse with water but did not check to see if the denture and partial plates were in place.

The Nurse Manager reported that the PSW, assigned to Resident # 2 on the evening shift of the same day, had indicated that the resident's upper denture was removed at bedtime but not the lower partial as the resident did not remove it by self. This PSW indicated to the Nurse Manager that it was felt that the lower partial plate was still in the resident's mouth at bedtime but the fact that it was not removed was not reported to the charge nurse or to the oncoming staff.

The PSW assigned to Resident # 2's care the next day, had indicated to the Nurse Manager that mouth care was not provided to Resident #2, because the resident was unwell.

On the third day following the onset of the respiratory event, the PSW assigned to Resident # 2 knew the resident was ill and did not provide mouth care or attempt to retrieve the upper denture and lower plate from the denture cup and therefore did not notice that the lower partial plate was actually missing.

As such, routine mouth care was not provided to Resident # 2 and the lower partial plate was not observed to be missing until the X-ray revealed the lower partial plate was lodged in the resident's throat. [s. 34. (1) (a)]

Issued on this 5th day of December, 2012

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

Colette Asselin, LTCH Inspector #134