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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 17, 2015	2015_297558_0003	T-1709-15	Resident Quality Inspection

Licensee/Titulaire de permis

MARIANN NURSING HOME AND RESIDENCE
9915 YONGE STREET RICHMOND HILL ON L4C 1V1

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

MARIANN HOME
9915 YONGE STREET RICHMOND HILL ON L4C 1V1

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

BARBARA PARISOTTO (558), JULIET MANDERSON-GRAY (607), VALERIE PIMENTEL (557)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): February 23, 24, 26, 27, March 2, 3, 4, 5, 6, 2015.

The following intake was completed concurrently with the RQI: critical incident report T-730-14.

During the course of the inspection, the inspector(s) spoke with the administrator, the director of care (DOC), the activities director (AD), the dietary services manager (DSM), registered dietitian (RD), RAI (resident assessment instrument) coordinator, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), chief cook, cook, dietary aides (DA), activation aides, housekeeper, maintenance worker, residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

13 WN(s)
5 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	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. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimetres.

On February 23, 2015, the windows located in the first, second and third floor spa rooms, and four identified resident rooms were observed opened. The inspectors proceeded to open the windows greater than 30 centimetres. The windows had screens in place. The doors to the spa rooms were unlocked and residents had unsupervised access.

On February 24, 2015, the administrator reported corrective action had been taken related to the windows in the above mentioned rooms.

On March 4, 2015, the home conducted an audit of windows in the home, including resident rooms and common areas. A record review of the audit revealed 45 of the 58 rooms/areas audited were identified without window locks. An interview with the administrator confirmed the majority of windows in the building opened beyond the legislated requirement, that window blockers have been ordered and will be installed. [s. 16.]

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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways and to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be, kept closed and locked.

On February 23, 2015, inspector #607 observed the basement doors leading to the east and south stairways unlocked. These stairways led to emergency doors that were unlocked and led to the outside of the home.
Residents were observed accessing the basement for activity programs.

On the same day, the south emergency door located in the main floor home area corridor was found unlocked. This door led to the home’s parking lot outside. Residents reside in this home area and have access to the door. [s. 9. (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 that all doors leading to stairways and to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be, kept closed and locked, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. Every licensee of a long-term care home shall ensure that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: abuse of a resident by anyone.

A review of Residents' Council minutes of a specified date, revealed a resident's concern of staff being rough during care. An interview with the Residents' Council assistant identified the resident that brought forward the concern.
A review of the DOC’s response to the Residents' Council and an interview with the DOC revealed the course of action taken regarding this concern was the home's abuse policy was reviewed during a meeting with staff on the identified home area.

An interview with the DOC confirmed that the identified resident was not interviewed and that the alleged incident was not investigated. [s. 23. (1) (a)]

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 every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: abuse of a resident by anyone, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

On an identified date, the inspector observed an alteration in skin integrity on resident #06's face. Four days later the same alteration in skin, as well as a new alteration in skin integrity was observed. An interview with an identified staff member stated he/she had informed the charge nurse on a specified date about the altered skin integrity for resident #06.

Record review of the plan of care did not identify any documentation of either alteration in skin integrity for resident #06. There was no skin assessment completed by the registered nursing staff.

Interviews with a registered nursing staff confirmed he/she did not complete a skin assessment using a clinically appropriate assessment tool. [s. 50. (2) (b) (i)]

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 a resident exhibiting altered skin integrity receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there are schedules in place for routine, preventative and remedial maintenance.

Throughout the inspection the inspectors observed dry wall damage, blistering paint and patched walls requiring painting in resident rooms and common areas. A record review and interview with the maintenance worker and administrator revealed an audit of the home was completed in November/December 2014 that identified rooms requiring repair and painting. The administrator indicated the maintenance worker is responsible for scheduling the repairs.

The maintenance worker confirmed that the identified rooms are addressed as time permits and are not scheduled. [s. 90. (1) (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 that, there are schedules in place for routine, preventative and remedial maintenance, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Infection Prevention and Control program is evaluated and updated at least annually in accordance with evidence-based practices.

An interview with the DOC confirmed that an annual evaluation is not conducted for the Infection Prevention and Control program. [s. 229. (2) (d)]

2. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

On an identified date during lunch service in the main floor dining room, the inspector observed a PSW clear soiled dishes, proceed to serve two entrees and sit down to feed a resident, without performing hand hygiene between tasks.
A hand washing sink is located in the dining room servery and hand sanitizing agent is located outside of the dining room door.

An interview with the PSW confirmed hand hygiene was not performed between each task. [s. 229. (4)]

3. On an identified date the inspector observed a resident receiving treatment involving bodily fluids in the hallway. A collection bag containing bodily fluids, was observed on the floor next to the resident.

An interview with the DOC confirmed the expectation is that the staff place the collection bag in a container and not directly on the floor. [s. 229. (4)]

4. The licensee has failed to ensure that there is access to point-of-care hand hygiene agents.

Throughout the inspection the inspectors observed that the residents' rooms were not equipped with point-of-care hand hygiene agents.

Hand hygiene agents were located outside 4 out of 36 resident rooms.
An interview with a PSW revealed hand hygiene is performed using soap and water in the spa room.
An interview with a RPN revealed hand hygiene agents are available in the hallways and on the medication cart.
An interview with the DOC confirmed hand hygiene agents should be in every room and that staff would have to exit the room to locate a hand hygiene agent. [s. 229. (9)]

5. The licensee has failed to ensure that all residents are offered immunization against tetanus and diptheria.

A record review revealed residents #08, #09 and #16 were not offered tetanus and diptheria immunizations.
Interviews with an RPN and the DOC confirmed residents are not offered tetanus and diptheria immunizations. [s. 229. (10) 3.]

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 there is access to point-of-care hand hygiene agents, to be implemented voluntarily.

WN #7: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

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 has failed to ensure that that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Record review of resident #37’s written plan of care revealed the following conflicting information:

- put two full length side rails up at all times when in bed for safety and
- elevate one bed rail (right/left) to assist resident to position self in bed, keep (right/left) bed rail lowered to permit resident to exit bed on strong side.

Staff interviews with an identified PSW, registered nursing staff and DOC confirmed that the written plan of care does not set out clear directions to staff and others who provide direct care to the resident with regards to the use of side rails. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care is based on an assessment of the resident's needs and preferences.

On an identified date and time the inspector observed resident #08's bed with two full bed rails raised. An interview with the resident revealed one rail is usually raised and that the resident will request for the second rail to be raised when in bed to prevent the resident from falling out of bed.

A review of the written plan of care did not locate use of bed rails for resident #08.
An interview with a PSW revealed the resident uses two full bed rails.

Interviews with registered staff revealed the resident requires one full bed rail for bed mobility however, the resident's preference is to have two bed rails up while in bed. [s. 6. (2)]

3. Record review of resident #11's written plan of care revealed the registered nursing staff completed a bowel and bladder assessment on admission and post hospitalization when there was a noted change in the resident's bowel and bladder function. The PSWs did not complete the seven day bowel and bladder assessment tool to monitor the resident's voiding pattern.

Staff interviews with the registered nursing staff and PSWs confirmed that they did not collaborate with each other in the assessment of the resident so that they are consistent and integrated and complement each other. [s. 6. (4) (a)]

4. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Resident #09 has an identified medical condition that requires nutritional intervention. A

review of resident #09’s plan of care of a specified date revealed the following:

- low phosphorus foods to be offered and
- limit milk to 125ml at breakfast.

A sign titled phosphorus/potassium restricted, on the servery refrigerator door, indicated: do not pour milk except 75ml at breakfast and small amounts in tea or coffee, and to provide resident #09 125ml only at breakfast.

On an identified date and time the resident was observed with a large glass of milk and a small glass of water during lunch. An interview with the PSW serving fluids revealed that the resident was provided milk and water.

After an identified period of time, the milk had been removed from the resident’s place setting. Upon interviewing the PSW and the RPN, the RPN instructed the PSW to provide the resident a glass of milk. The cook collaborated with the RPN who then removed the milk and informed the inspector that a mistake had been made.

An interview with the DSM revealed the cook removed the original glass of milk as the resident is to receive milk only at breakfast related to a prescribed diet. [s. 6. (7)]

5. On two identified dates resident #04 was observed to have food debris between his/her teeth before breakfast and after breakfast.
A review of resident #04's care plan revealed that the resident should receive mouth care in the morning, at bedtime and post meals.
An interview with a registered staff member and DOC confirmed that the resident should be offered mouth care as per the care plan.
An interview with a PSW revealed a lack of awareness of the care set out in the plan of care related to mouth care and confirmed care was not provided as specified in the plan of care. [s. 6. (7)]

6. The inspector observed resident #15’s bed on a specified date to have four half rails up on his/her bed while he/she was in bed and on another specified date the resident had two half rails up at the head of the bed.

Record review of resident #15’s written plan of care identifies the following to reduce falls when resident attempts to get out of bed: posey alarm on resident at all times, call bell pined to gown when in bed, floor mat beside bed when in bed. The plan of care does not

indicate to use bed side rails.

A staff interview with an identified PSW confirmed they put the side rails up to prevent the resident from getting out of bed even though the alternative measures are in place. An interview with the registered nursing staff confirmed the resident should not have the side rails up while in bed but to ensure the alternative measures are in place as identified in the plan of care.

The registered nursing staff and the DOC confirmed that the use of side rails was not part of the care set out in the plan of care to the resident and the care was not provided as specified in the plan. [s. 6. (7)]

7. The inspector observed on March 5, 2015, resident #37 lying in bed, the resident did not have a bed alarm. On March 6, 2015, the inspector observed on two occasions the resident did not have his/her wheelchair alarm attached to the wheelchair or his/her self, however, on the same morning an alarm was observed to have been attached to the resident's bed.

Record review of the resident's written plan of care revealed that the staff are to:

- continue hourly monitoring or more frequently,
- attach posey alarm to him/her while in bed or wheel chair so it will trigger if resident stands, and
- to respond promptly to any alarms and provide assistance as required.

Interviews with an identified PSW, registered nursing staff, and a recreation staff member confirmed that the care set out in the plan of care identified as having a bed and or chair alarm attached to resident at all times was not provided to the resident as specified in the plan. [s. 6. (7)]

8. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary.

A review of resident #09's plan of care dated February 12, 2015, revealed the resident is to receive small portions at meals and the resident dietary information sheet indicated small portions at 50%. On March 2, 2015, during a lunch observation the inspector observed resident #09 with a full serving of a submarine sandwich and minced

vegetables and the resident consumed the full serving of the submarine sandwich. An interview with the dietary staff member revealed the resident receives regular portions. An interview with the RD revealed the resident receives regular portions. After reviewing the plan of care the RD revealed this intervention was initiated by a previous RD as the resident would get overwhelmed with regular portions.

The RD revealed the resident eats regular portions and confirmed that the plan of care was not revised when the care set out in the plan was no longer necessary. [s. 6. (10) (b)]

9. On February 23, 2015, the inspector observed resident #12's hair was unclean and required washing. Follow up observations on February 27 and March 2, 2015, noted the resident's hair was clean.
A review of the plan of care dated September 6, 2014, revealed the following: only hair salon for hair care as per appointment. This intervention was initiated on May 26, 2010. Resident and staff interviews revealed that the resident attends the hair salon for haircuts however, the resident's hair is washed on bath days.

An interview with the DOC confirmed that the plan of care should be revised related to resident #12's hair care. [s. 6. (10) (b)]

WN #8: 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 home's policy Continuum of Care, page 7, revised September 2013, indicates to take any or all actions when there is a change in the health status that affects continence: use a voiding record for seven days if the resident demonstrates a change in voiding patterns.

Record review of resident #11's written plan of care revealed there were no voiding records for the resident completed by the PSWs.
Interviews with a identified PSW and registered nursing staff confirmed that the home did not comply with completing a voiding record for the resident. [s. 8. (1) (b)]

2. The home's policy Section 6, Monitored Medications, Policy #6-5, dated January 2014, identifies that the registered staff are to sign the Individual Monitored Medication Record each time a dose is administered.

The inspector observed on March 4, 2015, that the Individual Monitored Medication Record was not signed off for the administration of a specified medication on the evening of March 3, 2015.

Interviews with a registered nursing staff and the DOC confirmed that the home did not comply with the homes policy to sign off medication as it was administered. [s. 8. (1) (b)]

3. The home's policy Section 6, Monitored Medications, Policy #6-6, dated January 2014, identifies that monitored medications must be counted by two registered staff leaving and arriving at shift change together.

Interviews with two registered staff one from the day shift and one from the evening shift confirmed that they did not count the monitored medication at shift change together on March 3 and 5, 2015. An interview with the DOC confirmed that the registered staff must do a shift count of monitored medications together at the change of the shift. [s. 8. (1) (b)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's equipment is kept clean and sanitary.

On February 24, 2015, at 10:19 a.m. the inspector observed resident #02's wheelchair to be visibly soiled and unclean. Observations on February 26, and March 2, 2015, identified the same soiled areas.
A record review revealed resident #02's wheelchair was documented as cleaned on February 24, 2015, at 6:58 a.m. and March 3, 2015, at 12:13 a.m.
On March 3, 2015 at 11:20 a.m. the inspector observed resident #02's wheelchair to be visibly soiled in the same areas.

An interview with an RPN confirmed resident #02's wheelchair was unclean. [s. 15. (2) (a)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

An interview with the DOC confirmed that the home does not have an evaluation of the Skin and Wound program. [s. 30. (1) 4.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis.

On two specified dates the inspector observed resident #06 to have extensive facial growth.
Record review revealed in the resident’s written plan of care the resident requires assistance with personal hygiene including shaving on a daily basis.

Staff interviews with a PSW, a registered nursing staff member and the DOC confirmed the resident had extensive facial growth and that the resident was not shaved on a daily basis. [s. 32.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident receive fingernail care, including the cutting of fingernails.

On February 27, and March 2, 2015, resident #04 was observed to have long nails that were not cut or trimmed and were visibly unclean.
A review of the PSW task report revealed resident had bath on February 27, 2015.
A review of resident #04's care plan revealed that resident should have nails cut on baths days.
An interview with the registered staff and DOC confirmed that the resident nails should be cut on bath days and as needed.
An interview with the PSW confirmed that finger nail care was not provided. [s. 35. (2)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

Record review and an interview with the Residents' Council assistant revealed that the satisfaction survey was not developed with the advice of the Residents' Council. The administrator confirmed that the satisfaction survey was developed through an independent company outside the organization and that residents were not consulted in the development of the survey in 2013 or 2014. [s. 85. (3)]

Issued on this 1st day of May, 2015

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et 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 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BARBARA PARISOTTO (558), JULIET MANDERSON-GRAY (607), VALERIE PIMENTEL (557)
Inspection No. / No de l'inspection :	2015_297558_0003
Log No. / Registre no:	T-1709-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 17, 2015
Licensee / Titulaire de permis :	MARIANN NURSING HOME AND RESIDENCE 9915 YONGE STREET, RICHMOND HILL, ON, L4C-1V1
LTC Home / Foyer de SLD :	MARIANN HOME 9915 YONGE STREET, RICHMOND HILL, ON, L4C-1V1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bernard Boreland

To MARIANN NURSING HOME AND RESIDENCE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Order / Ordre :

The licensee shall prepare, submit and implement a plan that summarizes the following:

1. Short term actions to ensure safety of the residents who have access to windows that open to the outdoors and open more than 15 centimetres until corrective action can be completed. The plan should identify who is responsible for implementing these short term actions and a time frame for when the actions will be implemented.

2. Long term actions to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimetres. The plan should outline the tasks involved, who will be responsible for those tasks and the time frame for completion of the tasks.

Please submit plan to Barbara.Parisotto@ontario.ca by April 24, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimetres.

On February 23, 2015, the windows located in the first, second and third floor spa rooms, and four identified resident rooms were observed opened. The inspectors proceeded to open the windows greater than 30 centimetres. The windows had screens in place. The doors to the spa rooms were unlocked and residents had unsupervised access.

On February 24, 2015, the administrator reported corrective action had been taken related to the windows in the above mentioned rooms.

On March 4, 2015, the home conducted an audit of windows in the home, including resident rooms and common areas. A record review of the audit revealed 45 of the 58 rooms/areas audited were identified without window locks. An interview with the administrator confirmed the majority of windows in the building opened beyond the legislated requirement, that window blockers have been ordered and will be installed. (558)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 29, 2015

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire Commission d'appel et de révision des services de santé 151, rue Bloor Ouest, 9e étage Toronto (Ontario) M5S 2T5	Directeur a/s Coordinateur des appels Direction de l'amélioration de la performance et de la conformité Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Ontario, ON M5S-2B1 Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 17th day of April, 2015

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Barbara Parisotto

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