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

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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 11, 2018	2017_594624_0029	023195-17	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

BAIYE OROCK (624), LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 27, 28, 29, 30 and December 1, 2017

The following logs were inspected concurrently:
Log #019777-16 related to follow up of orders concerning windows, doors and bed rails in the home,
Log #008582-17 related to an anonymous complaint of alleged resident abuse,
Log #019672-16 related to an alleged improper care of a resident,
Log #021717-17, #009225-17 and 006815-17, all related to resident falls with injuries.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Dietary Manager, the Programs Manager, the Resident Assessment Instrument (RAI) Coordinator, the Registered Dietitian (RD), the Quality Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the presidents of Resident and Family Councils, residents and family members.

A tour of the home was completed, several observations made of resident to resident interactions, staff to resident interaction during the provision of care, and medication
administration. A review was also completed of the residents' health records, the licensee's internal investigation notes, resident council minutes, medication incident reports, professional advisory council (PAC) meeting minutes, as well as relevant policies and procedures related to falls management, zero tolerance of abuse and neglect, nutrition and hydration, skin and wound care, continence care, and minimizing of restraints.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
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.
- **5 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #003	2016_413500_0006	111
O.Reg 79/10 s. 16.	CO #001	2016_413500_0006	111
O.Reg 79/10 s. 9. (1)	CO #002	2016_413500_0006	111

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. 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:
13. Nutritional status, including height, weight and any risks relating to nutrition care. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1.The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's nutritional status, including height, weight and any risks related to nutrition care, and was based on an interdisciplinary assessment of the resident's hydration status and any risks related to hydration.

Review of the written plan of care for resident #006 indicated the resident had several specified diagnoses and ate a specified diet independently.

Review of the health care record over a two month period for resident #006 indicated:
-Over a specified period in the first month the resident was unwell, the resident intake was poor, the resident developed specified symptoms and a specified intervention was put in place. Seven days later, the resident`s Substitute Decision Maker (SDM) was notified of the resident's changing status. A day later, the resident was assessed by the Nurse Practitioner (NP) and interventions were put in place with an order to notify the physician if the resident`s condition worsened. A day after being seen by the NP, the physician saw the resident and ordered a specific intervention. Four days after the physician`s initial assessment, the resident was assessed again by the physician and a referral to the Registered Dietitian was ordered by the Physician. A day after the physician`s second assessment, a multidisciplinary care conference was held with the SDM. The Dietary Manager (DM) indicated at the care conference that the resident

condition remained poor, that they would trial a new intervention while awaiting consultation from the RD. The DM indicated also that the resident was already receiving the intervention ordered by the physician five days earlier (despite this not having been implemented as per orders and the DM was not aware that the order had not been implemented).

The SDM requested the resident be transferred to hospital if the resident continued to deteriorate. About three weeks after the onset of the resident`s health concerns, there were no improvements and the physician ordered another specified intervention. Three days later, the resident was assessed by the RD who then altered some already implemented interventions.

-A month after the onset of the resident health concerns, nursing noted the resident had a significant weight change and completed a second RD referral. The RD completed the referral the same day with no noted changes made to the resident`s care plan. Three weeks later, the residents situation deteriorated, the resident was assessed by the physician and there was a noted significant deterioriation to the resident`s condition. The SDM was contacted and the SDM indicated the resident should remain in the home for monitoring.

-Two months after onset of the resident`s health concerns, some improvement was noted in the resident`s condition and the frequency of a particular intervention was reduced as the resident was refusing the said intervention at particular times of the day.
Review of the licensee's policy related to the resident concern (revised October 2017) indicated a referral should be made when: a resident`s specified condition was less than 50 % requirement for 3 or more days or when a resident`s specified condition went below their established goal for several days or when the resident`s specified condition was altered from their usual pattern and when there is a change in a resident's medical condition.
Review of the electronic Medication Administration Record (eMAR) for resident #006 indicated that the resident refused a specified interventions at particular times during the day. A review of the weight of the resident also indicated that a month after the onset of the resident's health concerns, the resident lost 14% of their body weight. Two months after the onset of the health concern, the resident had lost approximately 17% of their body weight.

Interview with Dietary Manager (DM) by Inspector #111 indicated awareness of resident #006's deteriorating status over the two month period. The DM indicated awareness of

the first referral to the RD but indicated the RD was on personal leave of absence when the referral was made. The DM was not aware of the a specified intervention ordered by the physician two weeks after the onset of resident`s concern. The DM indicated the nursing staff were trialling some interventions while waiting for the consultation by the RD. The DM indicated this trial occurred the same day of the care conference. The DM confirmed awareness of no documented evidence of any direction by the DM to trial the interventions the DM indicated nursing was trialing. The only documented evidence of an intervention was one ordered by the RD approximately three weeks after the onset of resident`s concern and another ordered by the physician a month after the onset of the resident`s concerns.

Interview with RD by Inspector #111, indicated awareness of resident #006 poor status and awareness of first RD referrals completed approximately two weeks after the onset of resident`s concerns. The RD indicated awareness that RD referral should be completed if a resident has poor intake after 3 days. The RD indicated no awareness of interventions ordered two weeks after the onset of resident`s concerns. The RD indicated she usually visits the home weekly but was unable to come to the home until approximately four weeks after the onset of resident #006's concerns to complete an assessment due to personal leave of absence. The RD indicated awareness of the resident's significant weight changes.

Interview with RN #110 indicated that any residents who have a specified intake status, should have a RD referral completed after three days and the physician notified. The RN indicated the DM is to be notified of any new orders related to dietary concerns via email or phone and referrals to the RD are completed online with PCC. The RN indicated the referral is left open until the referral has been completed.

The plan of care for resident #006 related to the resident's concerns over the two month period was not based on the risks the resident was facing as the resident's status deteriorated for a period of 15 days before a referral was completed to the RD. The RD did not assess the resident until approximately four weeks post onset of resident's concerns and a specified intervention ordered by a physician was not implemented until 10 days after it was ordered. During the two month period of the concern, the resident lost approximately 17% body weight.

2. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's skin condition, altered skin integrity and foot conditions.

Observation of resident #008 by Inspector #111 on a specified date, indicated the resident had large bruising noted to specified body parts.

Interview with PSW #109 by Inspector #111 indicated awareness of bruising to resident #008's body parts and indicated the resident has the bruising from some responsive behaviors. The PSW indicated the bruising has been present for a long time.

Interview with RN # 110 by Inspector #111 indicated awareness of resident #008 having bruising/skin discolouration to the body part and indicated it was also over most of another body part of the resident. The RN indicated the resident has had the bruising present since admission and that the bruising was as a result of the excessive responsive behaviors. The RN indicated the resident receives a specified intervention and has cream applied as ordered. The RN indicated the admission skin assessment should have noted the bruising/skin discolouration to those areas.

Review of the health care record for resident #008 indicated the resident was admitted on specified date with specified diagnoses. A review of the resident's admission documentation did not indicate the location or cause of the bruising. Subsequent documentation did not indicate the resident had bruising or skin coloration to the identified body part.
The resident was exhibiting bruising/skin discolorations to a specified body part, as a result of identified responsive behaviors and the plan of care was not based on an interdisciplinary assessment with respect to the resident's skin condition. [s. 26. (3) 15.]

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 interdisciplinary assessments of the nutritional and hydration status of resident #006, and the skin condition of resident #008 are completed, and that these assessments are incorporated and reflected in the residents' plan of care, to be implemented voluntarily.

WN #2: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the SDM, if any, and the designate of the resident / SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care

Related to log # 006815-17,

A critical incident report (CIR) was submitted to the Director on a specified date for an incident that caused an injury to a resident for which the resident was taken to hospital and had a significant change in condition. The CIR indicated that resident #012 was found on a specified date and time with specified concerns to a particular body part. The physician ordered a test which was completed a day prior to the date the CIR was submitted. The results of the test indicated injury to the earlier mentioned body part. The CIR indicated the resident was dependent on the use of a specified mobility aide and had some harmful responsive behaviors which may have caused the injury noted to the said body part.

Review of the health care record for resident #012 indicated the resident was not able to make decisions about care. A review of the progress notes for resident #012 indicated the resident had sustained an unwitnessed fall approximately two weeks prior to the date the CIR was submitted to the Director. At the time of the fall, the resident did not have any injuries or pain noted. There was no indication the Substitute Decision Maker (SDM) was notified of the fall, until nine days later, when the resident was found with injuries to the body part in question. [s. 6. (5)]

WN #3: 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 the falls prevention and management policy was complied with.

Under O.Reg. 79/10, s. 48(1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

Review of the Licensee policy "Falls Prevention and Management" indicated under Post Fall Management: the Interdisciplinary team will notify the attending physician and ensure immediate treatment after a fall.

Related to Log # 009225-17,

A critical incident report (CIR) was submitted to the Director on a specified date and time for fall that resulted in injury for which the resident was taken to hospital and resulted in a significant change in the resident's condition. The CIR indicated that on an identified date, resident #022 was found on the floor at a specified location. The resident was complaining of pain to a specified body part but no visible injury was noted. The CIR indicated the physician was notified, the resident was transferred to hospital for assessment. The CIR was updated about a week after the fall and the report indicated the resident remained in hospital with a new specified diagnosis. The CIR was completed by the Director of Care (DOC).

Review of the progress notes for resident #022 indicated the resident only sustained one fall in the year the above fall incident occured. The notes indicated at a specified time, the staff were notified by a co-resident that resident #022 was on floor at a specified location. The resident was assessed, treated for pain to a specified body part with no visible injuries noted. A message was left for the both substitute decision makers (SDMs) of the resident. There was no indication the physician was notified. The physiotherapist (PT) assessed the resident after a referral was received and indicated the resident had pain to the specified body part. Sometime after voice messages were left for the SDMs, SDM #1 called the home and was asked if the SDM would like the resident transferred to hospital. The SDM indicated to monitor the resident for now at the home. Approximately two hours later, SDM #2 came to the home, spoke to the resident and indicated the resident was in pain and unable to move. The nurse then contacted SDM #1 again who agreed to transfer the resident to hospital. The resident was transferred via ambulance to hospital where the resident later passed away approximately two weeks later.

Interview with the DOC by Inspector #111 indicated the physician should have been called right after resident #022 had the fall and was experiencing pain. The DOC indicated the SDM may have had specific instructions to be called prior to sending a resident to hospital but this would have to be documented and the physician would still need to be called for further direction.

The licensee failed to ensure that the falls prevention and management policy was complied with as the physician was not notified after the resident sustained a fall, complained of pain and the resident was not transferred to hospital for assessment until after the family arrived in the home two hours after the fall and gave direction to transfer t

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WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The Licensee failed to immediate notify the Director of an incident of abuse of resident #026.

Related to log #019672-16,

Critical Incident Report (CIR) was submitted to the Director on a specified date. Accorded to the submitted CIR, resident #026 was restrained during the provision of care as resident was extremely restless, agitated, and exhibiting self-harm responsive behaviors. According to the CIR, the resident was restrained with a unauthorized device, restricting the resident's ability to move/use his/her hands.

A review of resident #026's progress notes revealed a documentation by RN #113 indicating that the abuse incident was discovered by RN #112 during morning rounds on an identified date. In an interview the Director of Care (DOC) on another identified date, the DOC indicated that the unauthorized device was applied by evening staff on the evening shift the day before the device was discovered (i.e. RPN #120 and PSW #119), left applied by the night PSW (PSW #121) and discovered by RN #112 the following morning. The DOC indicated that all three staff received three days suspension each and retraining. RPN #120, PSW #119 and PSW #121 were not available for interview.

The Licensee became aware of this incident of abuse in the morning of an identified date. The Director was notified of the incident in the afternoon of next day, more than 24 hours after the incident was discovered.

In separate interviews during the inspection with PSW #118, RPN #117, RN #113, the DOC and the Administrator, all indicated the expectation in the home is that any alleged or witnessed incident of abuse of a resident must be reported immediately to the Director. [s. 24. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that where a resident is being restrained by a physical device, that staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

Related to log #019672-17,

According to the Critical Incident Report above related to WN #4 above, resident #026 was restrained using an unauthorized device from the evening of an identified date, to the morning of the following date. (see WN #4 for details).

In separate interviews during the inspection with PSW #118, RPN #117, RN #113, and the DOC, all indicated that residents can only be restrained using physical devices that have been approved by a Physician or Nurse Practitioner and for which resident and/or Substitute Decision Maker (SDM) consent has been received. The DOC indicated that resident #026 was restrained using a physical device that was not approved by a Physician or Nurse Practitioner and that this should not have happened. [s. 110. (2) 1.]

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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

Issued on this 26th day of January, 2018

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

Original report signed by the inspector.