Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 25, 2021	2021_941746_0006	011020-21	Critical Incident System

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

AMANDEEP BHELA (746)

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 16-18 and 22, 2021.

One log related to a fall which resulted in injury.

Inspector #565 was also present during this inspection.

During the course of the inspection, the inspector(s) spoke with a Housekeeper, Personal Support Workers (PSW), Registered Practical Nurses (RPN),Physiotherapist (PT), Continuous Quality Manager (CQI Manager), Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector toured the home, observed Infection Prevention and Control (IPAC) practices, observed care activities on the units, reviewed relevant policies and procedures and reviewed resident records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 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	Légende 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 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).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001's written plan of care, set out clear directions to staff who provided direct care to the resident.

A Critical Incident Systems (CIS) report was submitted to the Director regarding the resident's fall with an injury.

A review of the resident's written plan of care indicated that a fall prevention intervention was to be applied to the resident at the time of the fall. Review of resident #001's progress notes indicated that the resident would refuse this, at times and remove the intervention.

Interview's with PSW#105 and RPN#106, indicated that they did not identify this intervention to be in place as intended, when they discovered the resident had fallen. Interview with the CQI Manager confirmed that, the resident had removed the fall prevention intervention prior to the fall. PSW #105, RPN#106, the PT and the CQI Manager indicated that after the fall, the intervention was changed. They further indicated this intervention was more effective in preventing falls as the resident would not remove the new fall prevention intervention when applied.

A review of resident #001's Point of Care (POC) tasks and written plan of care indicated that the fall prevention intervention was not revised on the same date.

The CQI Manager confirmed that failure to ensure that the resident's POC tasks and written plan of care are consistent with fall prevention measures related to the new fall prevention intervention which was implemented, may result in unclear directions to the staff.

Sources: Observations in resident room, resident #001's progress notes, written care plan, POC tasks; PSW #105, RPN #106, PT #107, and CQI Manager #1109. [s. 6. (1) (c)]

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 clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that RPN #102 participated in the home's infection prevention and control (IPAC) program.

An observation made during the inspection demonstrated an RPN walking down the hallway entering the main floor nursing station, with their face mask below their nose. RPN #102 acknowledged that they were not wearing their face mask appropriately, and that it should be covering their nose. Director of Care (DOC)/ IPAC Lead indicated that all staff are to wear their masks appropriately, explaining that the face mask needs to cover both the nose and mouth.

This observation demonstrated that there was a potential risk to the staff member and resident, as there could be transmission of infectious agents, including the possibility of the COVID-19 virus, if IPAC measures are not adhered.

Sources: Observations on first floor unit; interviews with RPN #102, and DOC/IPAC Lead #104. [s. 229. (4)]

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 staff participate in the implementation of the program, to be implemented voluntarily.

Issued on this 25th day of November, 2021

[redacted]

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

Original report signed by the inspector.