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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 25, 2014	2014_290551_0030	O-001111-14	Resident Quality Inspection

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

MEGAN MACPHAIL (551), AMANDA NIXON (148), HUMPHREY JACQUES (599), LISA KLUKE (547), SUSAN WENDT (546), WENDY PATTERSON (556)

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): November 3, 4, 5, 6, 7, 10, 11, 12 and 13, 2014.

The following inspections were completed concurrently with the Resident Quality Inspection:
O-001127-14, O-001012-14, O-000927-14, O-000606-14, O-000573-14, O-001217-14.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Housekeeping Staff, Registered Nursing Staff, the RAI-MDS co-ordinator, the Manager of Recreation and Volunteers, Unit Managers, the Building Automation Services Supervisor, the Director of Nursing, a Nurse Practitioner and the Chief Executive Officer.

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
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

6 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	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 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 ensure that Resident #003's plan of care was reviewed and revised when the resident's care needs changed.

On specified days in November 2014, Inspector #547 observed that Resident #003 had altered skin integrity. It was reported that Resident #003 scratched his/her skin. It was noted that Resident #003 had long finger nails, and that the nail beds contained dark, black matter. Dried blood was noted on his/her fingers. In an interview with Resident #003, he/she indicated that he/she cannot help but scratch and that he/she was aware that he/she has created lacerations with his/her nails.

A record review was conducted for Resident #003 and his/her diagnosis were noted.

Registered Nursing staff involved the resident's family member, and information regarding interventions that had worked in the past was received. The resident's physician and nurse practitioner had tried several methods to assist the resident with his/her skin condition without success. Resident #003 was assessed by a dermatologist who recommended that medicated cream be applied for a specified diagnosis.

Resident #003 continues to scratch his/her skin to the point of bleeding as recorded in the resident's progress notes nine times in a specified time period. In September 2014, a specific intervention seemed to deter the resident from scratching and self-excoriating, however this intervention was not added to the care plan. Resident's current and previous care plans indicated that he/she required his/her nails to be trimmed and cut on bath day twice weekly. Resident #003's care flow sheets for nail care were initialed eleven times in October 2014 and once in November 2014, indicating that nail care was completed.

Inspector #547 interviewed the Director of Nursing (DON) regarding the resident's current nail and skin conditions. The DON indicated that Resident #003's plan of care should have been updated, to reflect his/her needs with regards to being at risk for skin break down and potential for skin infections, to include the basic need to maintain his/her nails with daily trimmings and cleanings, as well as any other methods to deter the resident from scratching and reduce the chances of self-excoriation and infection. [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 that Resident #003's plan of care is reviewed and revised to reflect his/her care needs with regards to skin care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

On November 11, 2014 Inspector #547 observed Resident #021, who resides in a secure unit, standing in front of the locked medication cart outside of a specified room touching the medication cups, the bags for medication crushing and the medication crusher located on the top of the medication cart. Resident #022 who resides in a secure unit was observed to be independently mobile and to be going up and down a hallway moving residents' wheelchairs.

On November 11, 2014, Inspector #547 observed S #120 prepare medication for Resident #020 outside the resident's room from the medication cart. Staff #120 entered Resident #020's room and closed the door leaving the medication cart outside the room unlocked and unattended by registered staff for a five minute period. Upon her return to the unlocked medication cart, Resident #021 was noted to be standing within close proximity of the medication cart and required redirection to his/her room by S #120. S #120 signed for the medication and then locked the medication cart.

S #120 proceeded to prepare medication for Resident #023 outside of the resident's room. She entered Resident #023's room to administer the medications, leaving the medication cart outside the room in the hallway unlocked and unattended by registered staff. Resident #022 was wandering in this hallway, and stopped next to the medication cart while S #120 was signing for the administered medication.

Inspector #547 interviewed S #120 regarding the home's expectation of locking the medication cart when not attended to by registered staff, and S #120 indicated that she should have locked the cart each time she walked away from it to give medications to residents and that she had forgotten to do this on both occasions.

On November 12, 2014 Inspector #547 interviewed the DON regarding the home's expectation for keeping medication carts locked when not attended. The DON indicated that it was not acceptable to leave any medication carts unlocked and unattended by registered staff. [s. 129. (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 medication carts are kept secure and locked, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee failed to ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

On November 4, 2014 Inspector #547 observed that three shared resident rooms on the 2C unit had curtains that did not provide complete privacy to the residents' individual space within these rooms. On November 13, 2014, Inspector #547 observed that six out of seven shared resident rooms on the 2C and 2D units had privacy curtains that did not provide privacy to the resident's occupying these spaces as when the curtains were pulled together there was a one to three foot gap between the curtains.

The Director of Environmental Services was interviewed and indicated that he was not aware that the privacy curtains did provide adequate privacy to the residents in these shared resident rooms. He indicated that he would correct the situation as this was unacceptable for the residents living in these rooms. [s. 13.]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a Personal Assistance Services Device (PASD) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care.

During the RQI, Resident #001 was observed on several occasions to be seated in a wheelchair with a lap belt and table top applied. Resident #001 was not able to remove/release either device upon the request of Inspector #148.

Inspector #148 spoke with the unit RPN #S106 and a PSW #S108 who were familiar with the care of Resident #001, and both reported that the table top was to assist the resident with eating at meal times and snacks. Both confirmed the lap belt was in place as a restraint for resident safety. RPN #S106 confirmed the resident is not able to release himself/herself, either physically or cognitively, from the table top or lap belt.

The plan of care for Resident #001 was reviewed and did not include the use of a table tray as a PASD. As of November 6, 2014 the use of the table tray for Resident #001 had not been considered as a PASD and the health care record demonstrates that the requirements of section 33 have not been satisfied. [s. 33. (3)]

WN #5: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of an incident no later than one business day after the occurrence of the incident that caused an injury to a Resident for which the Resident was taken to a hospital, and that resulted in a significant change in the Resident's health condition.

Resident #053 experienced a fall on a specified day in September 2014 which resulted in transfer to hospital.

A review of the progress notes in Resident #053's health care record indicated that on a specified day in September 2014 the resident was admitted to hospital with a specified diagnosis. Another progress note stated that the hospital had been contacted for an update on the resident's status.

On November 12, 2014, Unit Manager (UM) #1 reviewed her notes regarding the incident and stated that she knew that Resident #053 had been diagnosed with a specified condition on a specified day in September 2014. UM#1 was not able to provide a reason as to why the MOH was not notified within one business day following the significant change in Resident #053's health condition. s. 107. (3) 4.]

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. (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).

Findings/Faits saillants :

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

During the course of the inspection, it was noted that hand hygiene agent dispensers were located in the corridor fixed to the wall beside the door to each residents' room, however no hand hygiene agents were observed inside any of the resident bedrooms or washrooms.

PSW, S #124 stated that pocket hand hygiene agents were available but that she did not carry one as she relies in the dispenser on the wall outside of the residents' room. PSW, #113 was observed in a resident's room and did not have a mobile cart or pocket hand hygiene agent with her. She stated that she used the dispenser on the wall for hand hygiene.

The Lead for Infection Prevention and Control, UM #2 was interviewed and confirmed that hand hygiene agents were not located in residents' rooms or washrooms and that staff used the dispensers in the hallway for hand hygiene. [s. 229. (9)]

Issued on this 8th day of December, 2014

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

Original report signed by the inspector.