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

Division de la responsabilisation et de la performance du système de santé
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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
Oct 7, 2015	2015_295556_0023	O-002837-15, O-001717-15, O-001715-15, O-002439-15, O-002728-15, O-002596-15, O-002589-15	Critical Incident System

Licensee/Titulaire de permis

MARIANHILL INC.
600 CECELIA STREET PEMBROKE ON K8A 7Z3

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

MARIANHILL NURSING HOME
600 CECELIA STREET PEMBROKE ON K8A 7Z3

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

WENDY PATTERSON (556)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 29, 30, October 1, 2, 5, 6, 2015

Complaint Log #O-002087-15 was also completed during this inspection. There were no areas of non-compliance issued related to this complaint.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Care (DOC), Unit Managers (UM), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Behavioural Supports Ontario Champion (BSO), Residents, and Substitute Decision Makers (SDM).

The Inspector also reviewed resident health care records, internal investigation documentation, internal incident reports, policies related to Intimacy, Sexuality and Sexually Expressive Behaviours in Long Term Care, Responsive Behaviours Program, New or Escalating Responsive Behaviours, Acute Responsive Behaviour Management, Abuse, Medication Errors, and Critical Incident System Mandatory and Critical Incident Reporting, and observed staff to resident, and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 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 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. Ontario Regulation 79/10, s. 114 (2) states that the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

During an inspection a specific Critical Incident Report was reviewed and indicated that on a specific date three residents were found to have missing transdermal narcotic patches.

The home's internal investigation documentation was reviewed and confirmed that on four days over a two week period residents were found to have missing transdermal narcotic patches.

In an interview the DOC stated that according to the home's policy a medication incident report was to be completed when a transdermal narcotic patch that had been administered to a resident was found to be missing. The DOC indicated that this type of incident would fall into the category of omission of medication.

The policy entitled Medication Errors was reviewed and stated that a medication error constitutes any involvement in the dispensing or administration of the following: #5 Omission of a medication. The policy further stated that for all medication errors a Medication Incident Report must be completed promptly and given to the DOC.

Inspector #556 requested the medication incident reports for the above mentioned dates and was advised by the DOC that medication incident reports had not been completed for two of the incidents that occurred on specific dates.[Log #O-002837-15] [s. 8. (1) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

During an inspection two Critical Incident Reports were reviewed and indicated that Resident #007 and Resident #004 both sustained specific injuries while being transported in a wheelchair by staff from one location to another within the home.

The following finding relates to Log #O-001715-15. A review of the progress notes in Resident #007's health care record indicated that a PSW was propelling Resident #007 by wheelchair to a specified location and the Resident's foot bumped into the doorway of the room.

A review of the internal investigation documentation indicated that Resident #007 complained of pain the evening following the incident and was sent for a specific test the next day, which indicated that the Resident had a specified injury.

The following finding relates to Log #O-002596-15. A review of the progress notes in Resident #004's health care record indicated that a staff member was propelling Resident #004 by wheelchair and a specified incident occurred that resulted in an injury to the resident.

A review of the internal investigation documentation indicated that following the incident the Resident was experiencing discomfort and was sent for a specific test the following day, which indicated that Resident #004 had a specified injury.[Logs O-002596-15, O-001715-15] [s. 36.]

WN #3: 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):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of a missing or unaccounted for controlled substance.

During an inspection a specific Critical Incident Report submitted by the home to the MOHLTC on a specific day was reviewed and indicated that on a specific day three residents were found to have missing transdermal narcotic patches.

The home's internal medication incident reports, and internal investigation documentation were reviewed and confirmed that on four specific days residents were found to have missing transdermal narcotic patches. The documentation on the incident reports also indicated that the RN Supervisor was notified on a specific date, and an email was sent to the Unit Manager.

A review of the progress notes for the evening of a specified date in Resident #004 and #008's health care record indicated that the RPN was unable to find the narcotic patches on either of the residents and the RN Supervisor was notified.

In an interview the DOC stated that the RN Supervisor is the person in charge when there is no manager in the home. The DOC further stated that she was away from the home for a week and when she came back to work she reminded the Unit Managers that the MOHLTC should have been notified of the incidents of missing transdermal narcotic patches, at which time a Critical Incident Report was submitted.[Log #O-002837-15] [s. 107. (3) 3.]

Issued on this 7th day of October, 2015

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

Original report signed by the inspector.