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

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Inspection de soins de longue durée

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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
Jun 29, 2016	2016_330573_0015	031373-15 / 004882-16 / 014815-16	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

ANANDRAJ NATARAJAN (573)

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): June 22, 24, 27 and 28, 2016.

The following critical incident logs were inspected: Log# 031373-15 related to a resident to resident alleged physical abuse; Log# 004882-16 related to a staff to resident alleged emotional abuse/neglect; Log# 014815-16 related to a critical incident the home submitted regarding suspected financial abuse.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Unit Manager, Director of Care (DOC) and Chief Executive Officer (CEO).

The inspector reviewed Critical Incident (CI) reports, reviewed residents health record (including care plans, progress notes, medication administration records, flow sheets), home's internal investigation report and the home's written policy to promote zero tolerance of abuse and neglect of residents. In addition, the inspector also observed resident care and resident rooms.

The following Inspection Protocols were used during this inspection:
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. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

On June 23, 2016, Inspector #573 conducted a critical incident inspection related to physical abuse between resident #001 and resident #002 on a specified date for which resident #002 was transfer to hospital.

Resident #001 was admitted in the home's secured unit with responsive behaviours. A review of resident #001's quarterly assessment at the time of incident, for behavioural and mood symptoms identifies that resident #001 has responsive behaviours. Resident #001 care plan was reviewed and updated with resident quarterly assessment.

Inspector #573 reviewed resident #001's nursing progress notes for three specific months prior to the incident which indicate:

On a specified day and time, resident #001 responded aggressively and hit resident #003, staff intervened and no injuries observed.
On a specified day and time, resident #001 observed pulling resident #002 from the neck and right arm, swinging resident #002 around. Staff immediately intervened both the residents were separated and redirected. No injury observed.
On a specified day and time, staff witnessed resident #001 being physically responsive with resident #003 and hit the resident with pair of shoes. Staff intervened and no injuries observed.
On a specified day and time, resident #001 became physically responsive slapping resident #002 in arm. Staff intervened and redirected with good effect. No injuries observed.
On a specified day and time, resident #001 pushed resident #002 and resident #002 landed on floor. Staff quickly intervened and redirected resident #001. Resident #002 was transferred to hospital for further assessment and diagnosed with an Injury.

Inspector #573 reviewed resident #001's care plan at the time of incident which identifies that resident has responsive behaviours related to cognitive impairment. But there was no information or any interventions in place for staff regarding resident #001's physical abusive responsive behaviours towards other residents on the unit, specifically towards resident #002.

On June 22, 2016, the Inspector spoke with RPN #101 who indicated that resident #001's agitated behaviours was managed with redirection. Following the incident on a specified date for which resident #002 was transferred to hospital. Resident #001 was on Dementia Observation System (DOS), seen by the home's Behavioural Supports Ontario (BSO) team and physician to manage resident responsive behaviours. RPN #101 indicated that resident #001's care plan was updated and reviewed identifying resident #002 as potential trigger for resident #001. Further the RPN #101 indicated that prior to the incident on a specified date, no specific interventions were in place in the resident #001's care plan to manage resident physical abusive responsive behaviours towards other residents on the unit.

On June 22, 2016, resident #001's care plan at the time of incident was reviewed. The unit manager RN #102 indicated to inspector #573 that resident #001's care plan prior to the incident on a specified date, did not identify nor provide clear direction for staff specifically related to resident #001's physical abusive responsive behaviours towards other residents. (Log # 031373 -15) [s. 54. (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee failed to ensure that the home's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents identifies with O.Reg 79/10, s.96 (c), (d) and (e).

In accordance with the LTCHA 2007, s.20 and O.Reg 79/10, s.96 every licensee of a long-term care home shall ensure that the home's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, (a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected, (b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate, (c) identifies measures and strategies to prevent abuse and neglect, (d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation and (e) identifies the training and retraining requirements for all staff, including, (i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and (ii) situations that may lead to abuse and neglect and how to avoid such situations.

On June 27, 2016, Inspector #573 reviewed the home's policy to promote zero tolerance of abuse and neglect of residents, titled "ABUSE" in the presence of the home's Director of Care (DOC). Upon review, it was determined that the home's written policy to promote zero tolerance of abuse and neglect of residents did not identify with O.Reg 79/10, s.96 (c), (d) and (e). The DOC indicated to Inspector #573 that the home's Abuse policy and procedure will be updated in accordance to the legislation requirement. (Log # 004882-16) [s. 96.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s.97 (2) in that resident and resident's substitute decision-maker (SDM), if any, were not notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

On June 28, 2016, Inspector #573 spoke with the home's Director of Care (DOC) who indicated that the home had completed their investigation of the incident of staff to resident abuse/neglect that had occurred on a specified date. The DOC indicated to the inspector that she had not notified the resident #005 or the resident #005's SDM of the results of the staff to resident abuse investigation. (Log # 004882-16) [s. 97. (2)]

Issued on this 29th day of June, 2016

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

Original report signed by the inspector.