Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 # / Registre no	Type of Inspection / Genre d'inspection
Oct 20, 2016	2016_286547_0027	013511-16	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

LISA KLUKE (547), LINDA HARKINS (126)

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): October 4,5,6,7 and 11, 2016

The following critical incidents reported by the home were also inspected concurrently during this inspection:

Four critical incidents log #'s:029844-16,029744-16,020752-16 and 028061-16 were related to medication administration
One critical incident log #023996-15 related to a resident who had a fall with injury
One critical incident log #019502-16 related to alleged resident to resident abuse and
One critical incident log #029530-16 related to alleged staff to resident abuse

During the course of the inspection, the inspector(s) spoke with residents, family members, the President of Resident's Council, Housekeepers, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Unit Managers, a Resident Assessment Instrument (RAI) Coordinator, a Maintenance Supervisor, the Director of Care (DOC) and the Administrator.

In addition the inspectors toured the home, reviewed resident health care records, resident mobility equipment cleaning schedules, resident council minutes, documents related to the home's investigations into critical incidents reported by the home and policies related to abuse and resident self administration of medications. The inspectors observed aspects of resident care and interactions with staff, along with medication administration and infection prevention and control practices.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
4 WN(s)
1 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. The licensee failed to comply with O. Reg. 79/10 s.8 (1)(b) 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 to be complied with, in that the home failed to ensure compliance with the following policy: "Resident Self Administration of Medication last revised 10-2015"

In accordance with O Reg 79/10,s.131 (6) where a resident of the home is permitted to administer a drug to himself or herself, the licensee shall ensure that there are written policies to ensure that the resident who do so understand: (d) the necessity for safekeeping of the drug by the resident where the resident is permitted to keep the drug on his or her person or in his or her room.

The licensee's policy and procedure titled "Resident Self Administration of medication" stated the following procedure:

1.The physician will provide a written order for medication to be left at the bedside
2.The resident will be instructed to keep all medication in a locked area at the bedside

On October 6, 2016, Registered Practical Nurse (RPN) #100 indicated to Inspector #126 during a medication administration observation that resident #012, #025 and #026 had physician's orders for self-administration of medications. Inspector #126 observed RPN # 100 at 1410 hours, bring resident # 012's specified medication tablets and noted that she left them at the resident's bed side as the resident was resting in bed. RPN #100 indicated to Inspector #126 that resident #012 would take them at a later time.

On October 6, 2016 at 1430 hours, Inspector # 126 returned to resident #012's room and the resident was noted to be sleeping in bed. The two medication tablets were observed inside the plastic cup beside the resident on the night table.

On October 6, 2016 Inspector #126 observed a plastic cup that contained a white tablet and an orange tablet on resident #025's bedside table at 1610 hours. Resident #025 was awake while resting in bed and indicated to Inspector #126 that he/she takes these medication tablets before supper.

On October 6, 2016 Inspector #126 observed a plastic cup that contained a white tablet

and an orange tablet on resident # 026's walker seat at 1613 hours. Resident was observed to be sitting up in a chair beside his/her bed and indicated to Inspector #126 that the nurse brings the pills and that he/she takes them before supper.

On October 6, 2016 Inspector #126 interviewed RPN # 106 working the evening shift regarding her observations of resident #025 and #026's medications at their bedsides. RPN #106 indicated that she did dispense the medications to resident #025 and # 026 and left the medications at their bedsides.

The Director of Care indicated to Inspector #126 on October 6, 2016 that as per policy, residents can self-administer their medications but it is expected that all medication are kept in a locked area at the bed side. [s. 8. (1) (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 the home's policy titled " Resident self-administration of medications" is complied with by registered nursing staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident mobility equipment is kept clean and

sanitary.

On October 4, 5, and 6, 2016 Inspectors #126 and #547 observed the following resident's mobility equipment:

Resident #018's walker was observed to be soiled with dry food matter including dried white matter on the black seat cushion. The metal frame of this resident's walker was also noted to have dust and debris and sticky dark matter on the right side.

Resident #022's cushioned back rest and seat cushion on the resident's wheelchair were noted to have brown matter and food debris. The resident's footrest was noted to have heavy build up of dust and debris.

Resident #023's cushioned seat for the resident's wheelchair was noted to have large amount of food debris and sticky dried matter. The resident's wheelchair frame was also noted to have a build up on both sides of sticky dried dark matter.

Resident #024's walker seat was observed on October 4 and 5, 2016 to have a heavy build up of debris and sticky dried food matter.

On October 6, 2016 Inspector #547 reviewed the resident unit's wheelchair books which are used by night shift personal support workers. These books contained wheelchair cleaning forms that identified day of the week, room numbers, dates, wheelchair/ walker spaces and signatures for staff.

The wheelchair cleaning form for:

1. Resident #018 indicated the resident's walker is to be washed weekly on a specified day of the week and the last date of cleaning of the resident's walker was a specified date three weeks earlier.

2. Resident #022 indicated the resident's wheelchair is to be washed weekly on a specified day of the week and the last date of cleaning of the resident's wheelchair was a specified date five weeks earlier.

3. Resident #023 indicated the resident's wheelchair is to be washed weekly on a specified day of the week and the last date of cleaning of the resident's wheelchair was a specified date three weeks earlier.

4. Resident #024 indicated the resident's walker is to be washed weekly on a specified day of the week and the last date of cleaning of the resident's walker was a specified date this week. Upon review of the wheelchair cleaning forms prior to today's date indicated that the resident's walker was last cleaned on a specified date six months ago.

Inspector #547 interviewed RPN #100 on October 6, 2016 regarding residents #018, #022, and #023's mobility equipment cleaning schedule. RPN #100 indicated that this schedule is accurate and that if the mobility equipment was cleaned at any other time, that it would only be indicated in this binder. RPN #100 further indicated that if staff notice a resident's mobility equipment to require cleaning, over and above the weekly cleaning schedule, that PSWs write it in the report calendar that is reviewed at every change of shift. Upon review of the report calendar book from September 1-October 6, 2016, there was no indication of any mobility equipment that required cleaning.

Unit Manager #103 indicated to Inspector #547 on October 6, 2016 that since the home has moved to electronic documentation, that it is possible that the documenting of the cleaning of this mobility equipment has not been done accurately, however resident's mobility equipment should not be soiled as identified and they would have to review the home's process for the cleaning of resident wheelchairs and walkers. [s. 15. (2) (a)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the witnessed incident of alleged staff to resident abuse that was reported to RN #116 by RPN #105 on a specified date was immediately investigated.

This critical incident of alleged staff to resident abuse that is related to log #029530-16, was reported by the home on a specified date in October 2016 to the Ministry of Health and Long-term Care.

On October 11, 2016 Inspector #547 reviewed the home's investigation documentation of the alleged witnessed staff to resident verbal abuse of resident #032 that occurred on a specified date in September 2016. Inspector #547 noted that the investigation began three days after the incident occurred by Unit Manager #107 after she became aware of the incident during a meeting with RPN #105. RPN #105 indicated to Unit Manager #107 that she reported this incident to the evening Charge RN #116 on the date it occurred.

RN #116 indicated to Inspector #547 on October 11, 2016 during a telephone interview that she was the Charge RN for the evening of the specified date of this incident. RN #116 further indicated that she did not begin any formal investigation of this incident or report this incident to the Director of Care in order to begin an immediate investigation.

On October 11, 2016 the Director of Care indicated to Inspector #547 that RN #116 was the Charge RN that evening and did not investigate the alleged staff to resident abuse immediately.[log #029530-16] [s. 23. (1) (a)]

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 has failed to ensure that the person who had reasonable grounds to suspect that verbal abuse of resident #032 by PSW #115 occurred, immediately report the suspicion and the information upon which it was based to the Director.

Verbal abuse is defined in O. Reg 79/10, s. 2.(1) as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

On October 11, 2016 Unit Manager #107 provided Inspector #547 the home's investigation documentation of the alleged witnessed staff to resident verbal abuse of resident #032 that occurred on a specified date in September 2016. This documentation identified that RPN #105 observed PSW #115 at resident #032's bedside talking to the resident in a loud voice in a threatening and intimidating nature after the resident was incontinent.

On October 11, 2016 RPN #105 indicated to Inspector #547 that she did not confront PSW #115 on the date of the incident about what she said to resident #032 but she called the Charge RN (RN #116) that evening. RPN #105 further indicated that she did not immediately report this suspected staff to resident verbal abuse to the Ministry of Health and Long-Term Care.

On October 11, 2016 RN #116 indicated to Inspector #547 during a telephone interview that she was the designated staff in charge in the home on this specified date during the time of this incident. RN #116 indicated that RPN #105 did report what PSW #115 said to resident #032 during personal care. RN #116 indicated that she should have called the Director of Care to report this incident immediately. RN #116 further indicated that she did not immediately report this incident to the Ministry of Health and Long-Term Care.

On October 11, 2016 Unit Manager #107 indicated to Inspector #547 that she was made aware of the suspected staff to resident verbal abuse of resident #032 three days after it had occurred. Unit Manager #107 initiated the critical incident report to the Ministry of Health and Long-term Care regarding an alleged staff to resident verbal abuse the next day, four days after the incident occurred.

The Director of Care indicated to Inspector #547 on October 11, 2016 that the home did not immediately report the suspected, witnessed verbal abuse of resident #032 to the Ministry of Health and Long-Term Care as required.[log #029530-16] [s. 24. (1)]

Issued on this 20th day of October, 2016

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

Original report signed by the inspector.