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

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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 5, 2017	2017_682549_0008	009853-17	Complaint

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

RENA BOWEN (549)

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 26, 28, 29, October 2, 3, 2017

During the course of the inspection, the inspector(s) spoke with a resident, family members, Personal Support Workers (PSW), Registered Practical Nurse (RPN), a Unit Manager (UM), the Director of Care (DOC) and the Chief Executive Officer (CEO).

The inspector reviewed a resident's health care file including plan of care, progress notes, Treatment Administration Records (TARs), Medication Administration Records (MARs), resident care flow sheets, the licensee's staffing schedules, staff education records and the licensee's investigation documentation. The inspector observed provision of care to residents, staff to resident interactions and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 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 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 failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it is based to the Director.
1. Improper or incompetent treatment of care of a resident that resulted in harm or risk of harm
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm

A complaint was submitted to the Ministry of Health and Long Term Care on a specific date in 2017 related to the care being provided to resident #001. The complainant was concerned that resident #001 had been abused as the resident sustained a significant injury of unknown cause.

Resident #001 was admitted to the home on a specific date in 2016. The Minimum Data Set assessment dated a specific date in 2017, indicates that resident #001's cognitive skills for daily decision-making is moderately impaired- decisions poor; cue or supervision required. The resident required two people assist for activities of daily living, mobility and transfers.

During an interview on September 25, 2017 resident #001 was unable to communicate what had happened to cause an injury on a specific date in 2017 to Inspector #549 as

the resident's communication abilities are noted to be limited due to a cognitive deficit.

During an interview with the SDM on September 21, 2017 it was indicated to Inspector #549 that during a visit with resident #001 on a specific date in 2017 the resident started rubbing a body part indicating that it was sore. The SDM lifted the bed covers and saw an injury on the resident. The SDM indicated that the Registered Practical Nurse (RPN) #100 was notified of the injury on that specific date in 2017.

Inspector #549 reviewed resident #001's progress notes for a specific period in 2017.

RPN #100 documented the injury in the progress notes on a specific date in 2017. The inspector was unable to locate any documentation indicating that RPN #100 notified the Registered Nurse (RN) in Charge of resident #001's injury on the specific date in 2017.

During an interview with the Director of Care (DOC) and Unit Manager #101 it was indicated to the inspector that the home's expectation is that the RN in Charge be notified of the injury.

During an interview with the DOC on September 28, 2017 it was indicated to Inspector #549 that she did not believe that the injury to resident #001 was abuse however, was unable to conclude after the licensee's investigation when, who or what caused the injury to resident #001. The DOC was aware that the SDM had written a concern to the licensee indicating that the injury to resident #001 was the result of suspected abuse or neglect.

During an interview with Unit Manager #101 on September 29, 2017 it was indicated to the inspector that she was notified through the home's 24 hour unit report on a specific date in 2017 of resident #001's injury. Unit Manager #101 assessed the injury on the morning of the specific date in 2017 and initiated the investigation into the cause of resident #001's injury. The Unit Manager indicated that at the time of being notified of the injury she was not thinking that the injury was the result of abuse or neglect. The Unit Manager indicated that the investigation could not identify when, who or what caused the injury to resident #001 and could not confirm that it was not the result of abuse or neglect.

During an interview with the Chief Executive Officer (CEO) it was indicated to Inspector #549 that the licensee dealt with the injury as a complaint from the SDM. The CEO indicated that resident #001 suffered an injury of unknown cause and that the resident's

SDM was reporting to the licensee that there was a suspicion that physical abuse had occurred causing the injury to resident #001. The CEO indicated to Inspector #549 that she does not know why the injury to resident #001 was not immediately reported to the Director as suspected abuse or neglect as it is the usual practice of the home to do so. [s. 24. (1)]

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 a person who has reasonable ground to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it is based to the Director. 1. improper or incompetent treatment of care of a resident that resulted in a harm or risk of harm. 2. Abuse of resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, to be implemented voluntarily.

WN #2: 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).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to set out clear directions to the staff and others who provide direct care to the resident.

Resident #001 was admitted to the home on a specific date in 2016. The Minimum Data Set assessment dated a specific date in 2017, indicates that resident #001's cognitive skills for daily decision-making is moderately impaired- decisions poor; cue or supervision required. The resident required two people assist for activities of daily living, mobility and transfers.

During an interview on September 21, 2017, with resident #001's SDM it was indicated to the inspector that the SDM had made a request to have the resident returned to bed after each meal to rest.

On September 28 and 29, 2017, Inspector #549 observed that resident #001 was returned to bed after breakfast and lunch to rest.

During an interview with PSW #102 on September 29, 2017 it was indicated to the inspector that resident #001 is to be returned to bed after meals.

During an interview with PSW #103 on October 2, 2017 it was indicated that resident #001's family had requested that the resident be put back to bed after meals to rest.

Inspector #549 observed the resident in a wheelchair at the nursing station on a specific date in 2017 an hour and 20 minutes after breakfast.

During an interview with the Unit Manager on September 29, 2017 it was indicated to the inspector that she was aware that the SDM had requested that the resident be returned to bed after each meal.

The current written plan of care last reviewed on a specific date in 2017 was reviewed by Inspector #549 and Unit Manager #101 on September 29, 2017. The current plan of care gives the following direction under sleep monitoring pattern: in the afternoon put the resident back to bed as family wants the resident to rest so they are able to visit with the resident in the evenings. There is no direction in the current plan of care given to the direct care staff or others to return the resident back to bed after each meal.

The licensee has failed to ensure that the plan of care sets out clear direction to direct care staff and others related to resident #001 being return to bed after each meal. [s. 6. (1) (c)]

2. The licensee has a failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Resident #001's current written plan of care last reviewed on a specific date in 2017 indicates under Focus: Eating: needs to be toileted before brought to the dining room, as well as, after meals and prior to going to bed. The written plan of care also indicates under Focus: Toileting: Please attempt to toilet resident any time the resident attempts to get out of bed. Establish a consistent toileting regime.

During an interview with the SDM on September 21, 2017 it was indicated to the inspector that the resident was not being provided care as agreed during a recent care conference specifically related to toileting of the resident.

During an interview with PSW #102 on September 29, 2017 it was indicated to Inspector #549 that the resident is not toileted as the resident is incontinent.

During an interview with PSW #103 on October 2, 2017 it was indicated to the Inspector #549 that the resident is toileted sometimes however, the resident does not go.

During an interview with the Unit Manager #101 on September 29, 2017 it was indicated to Inspector #549 that the expectation is that resident #001 is to be toileted as directed in the plan of care.

The licensee has failed to ensure that care was provided to resident #001 as directed in the resident's plan of care related to toileting. [s. 6. (7)]

Issued on this 6th day of October, 2017

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

Original report signed by the inspector.