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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 3, 2017	2017_658178_0014	019241-17	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

SUSAN LUI (178), RENA BOWEN (549)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): September 18, 19, 20, 21, 22, 25, 26, 27, 28, 2017.

The following Critical Incident Logs were inspected concurrently with this RQI:
-related to falls: 002246-17, 002294-17, 007285-17, 015122-17, 022723-17
-related to an allegation of resident to resident abuse: 003681-17
-related to an allegation of staff to resident abuse: 008649-17.
The following Complaint Log related to infection prevention and control practices was completed concurrently with this RQI: 018345-17.

During the course of the inspection, the inspector(s) spoke with residents, family members, the Chief Executive Officer (CEO), the Director of Care (DOC), the Quality Improvement/Risk Management Coordinator, Unit Managers, the Registered Dietitian (RD), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs).

During the course of the inspection, the inspector(s) toured residential and non-residential
areas, reviewed health care records, reviewed selected policies and procedures, observed a medication pass, observed resident care and staff to resident interactions.

The following Inspection Protocols were used during this inspection:
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)
3 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The licensee's policy titled Abuse, Neglect and Retaliation, effective 07-2006, revised September 2016, was reviewed by inspector #178. The policy indicates that any employee who witnesses or suspects abuse/neglect of a resident must immediately report the incident or suspicion to their supervisor/designate.

Review of an identified Critical incident Report (CIR) submitted by the home, indicated that Nurse Manager #126 was informed on April 26, 2017, that RPN #121 had concerns on April 23, 2017, that Resident #030 had been treated very badly by another staff member when providing the resident's bath.

During an interview with Inspector #178 on September 26, 2017, RPN #121 indicated that on an identified date, Resident #030 told her that he/she had been verbally abused and not treated nicely by PSW #123 that evening during and after a bath. RPN #121 indicated that she considered Resident 030's treatment as the resident described it, to be verbally and emotionally abusive. RPN #121 indicated that she did not report the abuse to her supervisor immediately, but waited until April 26, 2017. RPN #121 stated that she waited three days to report the abuse because she was not sure what she should do.

During an interview on September 28, 2017, the DOC indicated that RPN #121 failed to comply with the home's Abuse, Neglect and Retaliation policy because she did not immediately report suspected abuse of a resident to her supervisor/designate.

(008649-17) [s. 20. (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 their written policy to promote zero tolerance of abuse and neglect of residents is complied with, specifically with regards to immediate reporting of suspected abuse or neglect of residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that written strategies to prevent, minimize or respond to the responsive behaviours of resistance to care and verbally abusive behaviours, were developed to meet the needs of resident #030.

Review of Resident #030's medical record indicated that the resident has anxiety and requires one person assistance with most activities of daily living as a result of impaired cognition, mobility, strength and balance.

During an interview with inspector #178 on September 27, 2017, PSW #123 indicated that Resident #030 regularly resists baths, refuses assistance with personal care which the resident requires, and refuses medications. PSW #123 also indicated that the resident is frequently verbally abusive to staff while refusing the care, often cursing at them and threatening them.

During an interview with Inspector #178 on September 28, 2017, PSW #124 indicated that Resident #030 often refuses a bath or shower, and often refuses assistance with personal care which the resident requires. PSW #124 also indicated that the resident frequently curses, yells at and threatens staff, often shaking his/her fist. PSW #124 indicated that when Resident #030 exhibits these behaviours, the staff will try to explain that they are there to help, and if that doesn't work they will leave the resident for a while and the resident will usually calm down.

On September 28, 2017, RPN #118 indicated to Inspector #178 that Resident #030 often resists clothing changes, baths, grooming, assistance with most activities of daily living, and also resists receiving medications, often cursing at staff as the resident does so. RPN #118 indicated that the resident has been exhibiting these behaviours for over a year. RPN #118 indicated that when Resident #030 exhibits these behaviours, she will speak to the resident about the resident's life before entering the home, and this will sometimes cause the resident to be more receptive.

Review of Resident #030's Minimum Data Set (MDS) assessment dated June 14, 2017, indicated that the resident was assessed to resist care on four to six out of the seven day observation period, and that the resident's behaviour was not easily altered. Review of Resident #030's MDS assessment dated March 14, 2017, indicated that the resident resisted care on one to three days out of the seven day observation period, and that the resident's behaviour was not easily altered.

A review by Inspector #178 of Resident #030's plan of care revealed no written strategies, techniques or interventions addressing Resident #030's responsive behaviours of resisting care and being verbally abusive towards staff.

On September 28, 2017 the Director of Care reviewed Resident #030's plan of care, and indicated that it did not contain written interventions to address Resident #030's responsive behaviours of resisting care and being verbally abusive towards staff, and that she would expect the staff to ensure that a plan of care is in place addressing the resident's responsive behaviour needs.

(008649-17) [s. 53. (1) 2.]

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 written strategies to prevent, minimize or respond to the responsive behaviours of resistance to care and verbally abusive behaviours, are developed to meet the needs of resident #030, to be implemented voluntarily.

WN #3: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

A complaint was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date. The MOHLTC Infoline Complaint Information Report indicated that the complainant voiced concerns related to infection prevention and control practices. The complainant indicated in an email on an identified date, that two PSWs were observed providing personal care to resident #025. The complainant indicated that the PSWs entered the resident's room already gloved. They provided peri-care to the resident with the gloves on and then proceeded to use the same cloth and same gloves that were used for peri-care to provide care to an infected area in another location on the resident's body. The complainant indicated that one of the PSWs used the same gloves to open a jar of cream and scoop cream out of the jar and put the cream on the resident. The email indicated that both of the PSWs used the same gloves to touch care equipment in the resident's room and the resident's wheelchair.

During an interview with PSW #120 on September 26, 2017 it was indicated to Inspector #549 that she provided peri-care to resident #025 and the PSW #119 provided care to another identified area on the resident's body. She indicated that she did not enter the resident's room with gloves on. She went into the resident's bathroom and put clean gloves on. PSW #120 indicated to the inspector that she did not take off her gloves to get the container of cream out of the resident's side table once peri-care was completed. She also indicated to the inspector that she used the same gloves to scoop out cream from the container, apply the cream on the resident and get the cleaning solution for the cleaning of the other area on the resident's body. PSW #120 indicated that she was still gloved when touching care equipment in the resident's room and the resident's wheelchair.

During a telephone interview on September 26, 2017 with PSW #119 it was indicated to the inspector that she provided care to an identified area on resident #025's body. PSW #119 indicated that she did not enter the resident's room with gloves on. She went into the resident's bathroom and put clean gloves on. PSW #119 indicated that she used a clean cloth and did not use the same cloth that was used for the resident's peri-care. PSW #119 also indicated that she did not remove her gloves once the care was provided, and did have the same gloves on when touching care equipment in the resident's room and the resident's wheelchair.

During an interview with the Director of Care on September 26, 2017, it was indicated to the inspector that the home's expectation is that both PSWs participate in the implementation of the Infection Prevention and Control program by PSW #119 removing gloves and completing hand hygiene after providing peri-care, before touching the jar of cream, or applying the cream to the resident and removing the gloves and performing hand hygiene once care is completed. PSW #120 is expected to remove gloves and complete hand hygiene after providing care to the resident's infected area of the body, before touching supplies or equipment in the resident's room.

(018345-17) [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #4: 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. (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 ensure that the care set out in Resident #027's plan of care was provided to the resident as specified in the plan.

Review of the medical record indicated that Resident #027 is at nutritional risk related to cognitive impairment and low weight.

On September 25, 2017, the home's Registered Dietitian (RD) indicated to Inspector #178 that the interventions to promote weight gain for Resident #027 include a recent order for a nutritional supplement three times daily.

Review of Resident #027's Physician's Order Form indicated that on an identified date, the RD wrote an order for the resident to receive an identified nutritional supplement, three times daily after medications. Review of Resident #027's electronic medication administration record (eMAR) indicated the resident should receive the nutritional supplement three times daily, beginning on an identified date.

At approximately 1445h on an identified date, Registered Practical Nurse (RPN) #114 indicated to Inspector #178 that she was unaware that Resident #027 had been ordered a nutritional supplement. RPN #114 indicated that she was the person responsible for providing the supplement to Resident #027 that day, and indicated that she had not provided the resident with two prescribed doses of the supplement that day as ordered, even though the order appeared on the resident's eMAR. RPN #114 indicated that Resident #027 refused morning medications, so RPN #114 administered the resident's morning medications at lunchtime, but missed the order for the supplement. RPN #114 indicated that she would administer Resident #027's nutritional supplement right after our interview.

Review of Resident #027's progress notes indicated that RPN #114 provided the resident with the nutritional supplement at 1505h on the day of her interview with Inspector #178. [s. 6. (7)]

Issued on this 4th day of October, 2017

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

Original report signed by the inspector.