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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Mar 28, 2018	2018_658178_0003	024405-17, 027390-17, 028066-17, 028573-17, 003314-18	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

SUSAN LUI (178)

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): February 26, 27, 28, March 5, 6, 7, 8, 9, 12, 13, 28, 2018.

The following Critical Incident Intake Logs were inspected as part of this inspection:
024405-17, involving an incident which causes injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status,
027390-17, 028066-17, and 028573-17, involving resident falls with injury,
003314-18, involving an unexpected resident death.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Unit Managers (UMs), Registered Dietitian (RD), Director of Care (DOC), Manager of Environmental Services, Chief Executive Officer.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, the resident's bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Review of the Resident #005's health record indicated that the resident requires assistance to mobilize in bed.

Inspector #178 interviewed Registered Practical Nurse (RPN) #120 on March 8, 2018 regarding resident #005. RPN #120 indicated that resident #005 received a new bed a few months ago. RPN #120 indicated that resident #005's current bed system includes partial side rails at the head of the bed, on both sides, and also includes an identified type of mattress.

On March 8, 2018, Inspector #178 observed resident #005's bed. The bed included an identified type of mattress, and two partial rails at the top of the bed.

Inspector #178 interviewed the Manager of Environmental Services (ESM) on March 8, 2018. The ESM indicated that the resident's present bed system has not been evaluated for risk of bed entrapment. The ESM provided Inspector #178 with records indicating that the most recent bed evaluation for resident #005 was done in July 2017, when resident #005 had a different bed system. The ESM indicated that resident #005's present bed system includes an identified type of mattress, and it is the home's practice to not test for entrapment on beds with tese types of mattresses, as it is their understanding that these beds will fail entrapment testing and are exempt from entrapment testing. The ESM indicated that resident #005's present bed system was not evaluated for any of the zones of entrapment, including the space located within the perimeter of the rail, which is unaffected by the type of mattress used on the bed. (024405-17) [s. 15. (1) (a)]

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 with O. Reg. 79/10, s. 15 (1)(a), to ensure that where bed rails are used, each resident's bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, including those residents who use an air mattress or therapeutic surface as part of the bed system, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Review of progress notes for resident # 005 indicated that the resident had impaired skin integrity in a specified location, identified on a specified date.

Review of resident #005's wound assessments on the home's electronic documentation system, Point Click Care (PCC), indicated no record of a wound assessment completed using a clinically appropriate assessment instrument when the impaired skin integrity was first identified on the specified date. Multiple progress notes over the following two months documented the impaired skin integrity, and treatments of the impaired skin. However, no wound assessment using a clinically appropriate assessment instrument appeared in the resident's record until approximately two months after the impaired skin was initially identified. On a specified date, approximately two months after the impaired skin was initially identified, an assessment was completed of the impaired skin using the Weekly Record of Wound Status assessment instrument on PCC. This assessment instrument recorded details about the impaired skin, such as length, width, depth, appearance of the impaired and surrounding skin, odour and presence of pain and exudate. Approximately six months after the impaired skin integrity in a specified location was first identified, an assessment of resident #005's impaired skin was completed using the Wound Assessment Revised 6-2014 assessment tool on PCC. This assessment instrument recorded further details regarding the resident's wound and wound care, such as date of onset of the wound and past treatments of the wound.

On March 8, 2018, Inspector #178 interviewed RPN #120 regarding resident #005's impaired skin integrity and the home's wound assessment processes. RPN #120 indicated that when a resident's wound is first identified, the more detailed Initial Wound Assessment is completed and documented on PCC by registered nursing staff, and then the wound is reassessed weekly by registered nursing staff using the Weekly Record of Wound Status on PCC. RPN #120 indicated that resident #005's specified area of impaired skin should have been assessed by registered staff when it was first identified, using the Initial Wound Assessment form on PCC. RPN #120 reviewed resident #005's health record and found that the first Wound Assessment on PCC for resident #005's specified area of impaired skin was completed on an identified date, approximately six

months after the impaired skin was first identified.

Inspector #178 interviewed Unit Manager (UM) #117 on March 8, 2018 regarding resident #005's impaired skin integrity. UM #117 indicated that registered staff should have assessed resident #005's impaired skin, using an Initial Wound Assessment form on PCC when the impaired skin was first identified. Registered staff would then be expected to reassess the wound weekly using the Weekly Record of Wound Status assessment instrument on PCC. UM #117 indicated that it appeared that staff did not assess resident #005's specified area of impaired skin integrity using the initial Wound Assessment instrument on PCC until a specified date, approximately six months after the impaired skin was initially identified. UM #117 further indicated that there were many progress notes regarding resident #005's area of impaired skin integrity, but those notes did not contain information which would be found in the initial and weekly wound assessment instruments, such as measurements of the wound.
(024405-17) [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident who is dependent on staff for repositioning has been repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, and while asleep if clinically indicated.

Review of resident #005's plan of care for potential for altered skin integrity on an identified date, indicated that the resident was to be turned and repositioned with skin care every two hours. The resident's plan of care for mobility on the identified date, indicated that the resident required the assistance of staff for bed mobility.

Inspector #178 interviewed Unit Manager #112 on March 9, 2018, regarding resident #005's care needs. UM #112 indicated that on the identified date, resident #005 had impaired skin integrity and required repositioning every two hours during the night.

Interview with PSW #122 on March 8, 2018, indicated that when caring for resident #005 on the identified date, the resident was not repositioned every two hours. PSW #122 indicated that the resident would have been repositioned by evening staff before they left at 2300h, and then was repositioned by PSW #122 and a co-worker between 0130h and 0200h. PSW #122 indicated that the resident was next repositioned at approximately 0500h. PSW #122 indicated awareness that resident #005 had impaired skin integrity and that the resident's plan of care required the resident be repositioned every two hours. PSW #122 indicated that there is not time during the shift to reposition the

resident every two hours, as staff would be occupied caring for other residents. (024405-17) [s. 50. (2) (d)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment
- the resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, and while asleep if clinically indicated, to be implemented voluntarily.

Issued on this 1st day of May, 2018

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

Original report signed by the inspector.