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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 27, 2018	2018_559142_0013	002850-18, 003137-18, 018386-18, 025113-18, 028374-18	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

JANET MCPARLAND (142)

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): November 5, 6, 7, 8, 14, 15, 16, 19 and 20, 2018.

The following intakes were inspected during this complaint inspection:
-Logs # 002850-18, 003137-18, 018386-18, 025113-18, 028374-18 related to staffing and resident care.

During the course of the inspection, the inspector(s) spoke with residents, family members, substitute decision makers (SDMs), Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Director of Care (DOC) and the Administrator.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **1 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	Légende 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. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home is bathed, at a

minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A review of the current plan of care for resident #001 indicated that the resident was scheduled to receive two baths per week on specific days of the week. In reviewing the resident's health record, it was noted that the resident did not receive their baths on identified dates in September, October and November.

A review of the current plan of care for resident #002 indicated that the resident was scheduled to receive two baths per week on specific days of the week. In reviewing the resident's health record, it was noted that the resident did not receive their baths on identified dates in September, October and November. On an identified date in November, it was noted in the progress notes that resident did not receive their bath due to staffing issues. In an interview with the SDM for resident #002, they indicated the resident did not receive their baths on the identified dates. They further indicated that on an identified date in November resident received a bed bath which is not the resident's bathing choice and at which time they did not have their hair washed. The resident's SDM indicated that staff advised them that the resident did not receive their bath as the resident home area was staffed with less staff than normal.

The current plan of care for resident #003 indicated that the resident was scheduled to receive two baths per week on specific days of the week. In reviewing resident's health record it was noted that the resident did not receive their baths on specific dates in September, October and November. In an interview with resident's SDM, they indicated that they were aware of days when the resident did not receive their scheduled bath. The SDM further indicated that they noted that the resident did not receive their baths when the resident home area was working with less staff than regularly scheduled.

In review of the resident #004's health record it was noted that the resident did not receive their baths on specific dates in November.

In review of the unit schedule for resident home area from September 1st to October 31st, 2018 it was noted that on the above noted dates that staffing mix was not according to the staffing plan. In interviews with PSWs #102, 106, 107, 109 and RPN # 104, they indicated that when the resident home area is not staffed as per the staffing plan, the residents do not always receive their baths as per their plans of care.

The licensee failed to ensure that residents #001, 002, 003 and 004 received their scheduled baths as specified in their plans of care. [s. 33. (1)]

Issued on this 28th day of December, 2018

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

Original report signed by the inspector.