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

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

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Apr 02, 2019	2019_505103_0009 (A1)	030738-18	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

Amended by DARLENE MURPHY (103) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

A error in date required correction on Licensee copy of the report; error was found and corrected prior to locking Public report; no amendments to public report required.

Issued on this 2 nd day of April, 2019 (A1)

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

Original report signed by the inspector.

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 25-29, 2019.

Log #030738-18-complaint related to staffing and resident care.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses, Scheduling clerks, Unit Managers and the Administrator.

During the course of the inspection, this inspector made resident observations and reviewed resident health care records.

The following Inspection Protocols were used during this inspection:

Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

During the course of the original 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 each resident of the home was 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.

Resident #004 was interviewed and indicated they are scheduled to have a tub

bath twice a week, but on a number of occasions, they have been unable to have their tub bath due to the staffing level of the unit. Resident #004 stated when this occurs, the staff assist the resident with a sponge bath. According to resident #004, they have missed approximately two to three baths each month and that the missed baths are not made up on another day. [s. 33. (1)]

2. Resident #005's plan of care related to bathing was reviewed and indicated they were to receive a tub bath or shower twice weekly. During a review of this resident's progress notes, an entry was made on an identified date in December 2018 (day shift) by RPN #104 to indicate the resident received a bed bath.

RPN #104 was interviewed and stated resident tub baths and showers frequently need to be cancelled due to short staffing of PSW's. RPN #104 stated that when the unit is short PSW's, it is unsafe to have two PSW's in the tub room as it would leave no one on the unit to monitor the other residents or to answer call bells. RPN #104 could not specifically recall the reason for their entry of a bed bath for resident #005 on the identified date in December 2018, but stated they document each time a resident's preferred method of bathing is missed in the resident progress notes.

Scheduling clerk #108 was interviewed and was able to confirm the home worked short one PSW and four hours RPN for the day shift on the identified date in December 2018. [s. 33. (1)]

3. Resident #006's plan of care related to bathing was reviewed and indicated the resident preferred a shower twice weekly. During a review of the resident progress notes, it was noted that on an identified date in February 2019 (day shift) an entry was made by RPN #105 stating the resident's bath was not completed due to time constraints. RPN #105 was interviewed and stated the unit was short PSW staff on that date and that some resident baths/showers were cancelled. RPN #105 provided similar information to this inspector as RPN #104 in regards to short staffing and the need to cancel resident tub baths/showers at times.

Scheduling clerk #108 was interviewed and was able to confirm the home was short one PSW for the day shift on the identified date in February 2019. [s. 33. (1)]

4. Resident #007's plan of care related to bathing was reviewed and stated the resident preferred a tub bath twice weekly. During a review of the resident's progress notes, RPN #106 documented on an identified date in November 2018

(day shift) resident #007 did not receive a tub bath due to short staffing and that a bed bath was completed. RPN #106 was interviewed and stated resident baths are cancelled at times as a result of short staffing. RPN #106 stated the home attempts to fill all empty shifts, that overtime is offered and when a unit is working short, staff from another unit may be pulled to assist the unit that is short staffed. RPN #106 stated the home has been attempting to hire additional PSW's.

Scheduling clerk #108 was interviewed and was able to confirm the home worked short two and one half PSW's for the day shift on the identified date in November 2018. [s. 33. (1)]

5. Resident #009's plan of care related to bathing was reviewed and indicated the resident preferred a tub bath twice weekly. On an identified date in December 2018 (evening shift), RPN #107 documented the resident was given a bed bath. RPN #107 confirmed during an interview the bed bath was given instead of the tub bath as a result of short staffing.

Scheduling Clerk #108 was able to confirm the home worked short one PSW on the evening shift on the identified date in December 2018. Scheduling Clerk #108 indicated the home has had past problems successfully filling sick calls especially for the PSW's, but indicated they felt over the past several weeks there were less shifts working short. Scheduling Clerk #108 stated two new PSW's had just recently been hired and were currently orientating in the home and that this should help to resolve the previous short staffing issues.

Unit Manager #112 was interviewed and stated the schedulers send an email out each day at 1300 hour to inform all managers of the staffing levels. Unit Manager #112 stated the managers then offer overtime to the staff. If this is unsuccessful, the managers look at the staffing needs of each unit and develop a strategy to pull staff from one unit to another for either the entire shift or for partial coverage to assist the unit working short. Unit Manager #112 stated the home continues to seek additional PSW staff to hire, but the current shortage of PSW staff is making this difficult. [s. 33. (1)]

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Original report signed by the inspector.