Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jan 10, 2020	2019_770178_0027	019631-19, 020901-19	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

SUSAN LUI (178)

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): December 10, 11, 12, 13, 16, 17, 18, 19, 20, 23, 2019 onsite of Long-Term Care Home; January 2, 3, 8, 2020 offsite.

Complaint Logs #020901-19 and #019631-19 regarding shortage of staffing were inspected.

During the course of the inspection, the inspector(s) spoke with residents, families of residents, Personal Support Workers, Registered Practical Nurses, Registered Nurses, Student Support Worker, RAI Coordinator, Recreation Programmer, Restorative Care Worker, Dietary Aides, Schedulers, Manager of Nutrition Services, Unit Managers, Director of Care (DOC), Chief Executive Officer (CEO).

During the course of the inspection the inspector also observed the provision of care and services to residents, residents' environment, reviewed residents' health records, bathing schedules, staffing plans, schedules and staffing plan review minutes.

The following Inspection Protocols were used during this inspection:
Dining Observation
Personal Support Services
Sufficient Staffing

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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented for resident #002 and resident #008.

Unit Manager #130 indicated that when a resident receives a bed or sponge bath rather than their preferred tub bath or shower, the PSW is expected to inform the RPN, who will chart this in the resident's progress notes.

The bath schedule for B Wing indicated that resident #002's preferred bath is a tub bath. PSW #110 indicated that on an identified date, resident #002 received a bed bath instead of their preferred tub bath because the unit was short staffed with only three PSWs, and because of other identified extenuating circumstances. PSW #110 indicated that when they provide a bed bath in lieu of a resident's preferred tub bath or shower, they document as usual in Point of Care (POC) that a bath was provided because a bed bath is considered a full bath. PSW #110 indicated that they tell the RPN when this happens, and it is up to the RPN to chart in the progress notes that a bed bath was provided rather than the resident's preferred bath. The POC charting by PSW #110 indicated that resident #002 received a bath on the identified date, but did not specify the type of bath. Progress notes for resident #002 did not indicate that the resident received a bed bath in lieu of their preferred method of bath on the identified date. RPN #108, who was working on the identified date, indicated that they did not chart in the progress notes that resident #002 did not receive their preferred bath because the PSW did not inform them of this.

The plan of care for resident #008 indicated that their preferred bath is a tub bath. PSW #113 indicated that on an identified date, B Wing was short staffed with three PSWs and as a result resident #008 received a bed bath rather than their preferred tub bath. The POC charting by PSW #113 indicated that resident #008 received a bath on the identified date, but did not specify the type of bath. Progress notes for resident #008 did not indicate that a bed bath was provided rather than the resident's preferred type of bath.

As such, the licensee failed to ensure that the provision of the care set out in the plan of care was documented for resident #002 and resident #008. [s. 6. (9) 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 the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan for the program of personal support services provided for a staffing mix that is consistent with residents' assessed care and safety needs. Specifically, the minimum number of PSWs in the staffing plan on days and evenings on B Wing failed to ensure that:
-residents consistently received their bath of choice twice weekly
-residents received timely assistance with breakfast on days when restorative care and recreation staff were not scheduled to assist in the B Wing dining room

The licensee's staffing plan for B Wing (39 residents) was provided by the CEO to Inspector #178. Inspector #178 reviewed the staffing plan (revised September 2019) with the CEO and the staffing plan indicated that on day and evening shifts the desired number of PSWs is 4, and the minimum number of PSWs is 2. The staffing plan indicated the following: units are not scheduled at minimum levels; this number reflects the minimum staff level for units to function on, when all other options have been tried (eg. overtime, support workers, staff from other departments, etc.) The CEO indicated that the staffing plan was based on the number of residents on the unit and their acuity and care needs. The CEO indicated that attempts are made daily to fill the shifts with the desired number of PSWs, including offering overtime. If the shifts cannot be filled, then the minimum number of PSWs in the staffing plan indicates the minimum number of PSWs needed to provide the care to residents. The CEO also indicated that when the desired number of PSWs are not available, staff from other disciplines, such as recreation and environmental services are brought in to assist with tasks such as transporting residents to and from the dining room, or answering call bells and obtaining assistance from the PSW and nursing staff as needed. The staffing plan does not specifically state who will assist with breakfast in the B Wing dining room.

A)
Family member #140 indicated to Inspector #178 that residents on B Wing who have tub baths scheduled in the evenings often miss one of their two scheduled tub baths per week because of short staffing on evenings. Family member #141 indicated to Inspector #178 that their loved one on B Wing did not receive their preferred tub bath on an evening the previous week because the unit was short staffed.

PSWs #100, #101, and #103 were interviewed and all indicated that more often than not, B Wing is staffed on days and evenings with fewer than four PSWs. The PSWs indicated that this is especially true on weekends but happens during the week as well. The PSWs all indicated that on days and evenings when B Wing is staffed with two or three PSWs, it is common for some residents to receive a bed or sponge bath in lieu of their preferred tub bath or shower because a sponge/bed bath takes less time. The PSWs indicated that most residents are scheduled two baths of their choice per week, and staff tries to ensure that the same resident does not have their preferred bath changed to a sponge/bed bath twice in one week.

RPN #102 indicated that B Wing has fewer than four PSWs to work days and evenings more often than not, primarily on weekends, and at least once or twice during the week.

RPN #102 indicated that on the days and evenings when there are fewer than four PSWs working on B Wing, some residents may receive a sponge bath in place of their preferred tub bath or shower.

On an identified date, the white board which lists the staff working on B wing indicated that three PSWs were working that evening. At approximately 1815h, PSW #106 indicated to Inspector #178 that they had completed three of the five baths scheduled for that evening, and it was unlikely they would complete the other two as they had 39 residents to put to bed.

On an identified date, the white board on B Wing indicated that three PSWs were working the evening shift. The next day, PSW #113 indicated that they worked on B Wing the previous evening with three PSWs, and resident #008 had received a bed bath rather than their preferred tub bath because the PSWs had run out of time.

On an identified date, at approximately 1415h, RPN #105 indicated that they worked on B Wing with two PSWs from 0700h until 0900h that day. An environmental services employee assisted with transporting residents to the dining room, and a Unit Supervisor assisted in the dining room for breakfast. At 0900h a third PSW came in. RPN #105 indicated that five out of seven residents did not receive their preferred bath that day, due to short staffing, and there was no plan to make up those baths on other shifts.

All staff interviewed indicated that when a resident receives a bed bath in lieu of their preferred bath, it is unlikely that the preferred bath will be rescheduled on a subsequent shift, as there will be other residents' baths scheduled for those shifts, normally making this impossible. PSW staff indicated that when a resident receives a sponge bath in lieu of a tub bath or shower, the resident would not likely have their hair washed.

B)
Dietary Aide #107 indicated to Inspector #178 that PSWs are usually not available to assist with providing drinks, serving breakfast, or setting residents up for their breakfast in the B Wing dining room. On most weekday mornings Restorative Care Worker #112 and Recreation Programmer #111 assist with these tasks in the B Wing Dining Room. However, on the days when these employees are not scheduled to work, this leaves only the unit RPN, who is also occupied with providing medications to the residents. Dietary Aide #107 indicated that on an identified date, they were working alone in the dining room for breakfast, attempting to serve residents their drinks, take resident's orders, make toast, and serve the breakfast because the employees from Recreation and

Restorative Care were not working, and the RPN and PSWs on B Wing were unavailable to assist them. Dietary Aide #107 indicated that this resulted in residents having to wait longer than usual for their meals and drinks, and residents became impatient and began yelling at the Dietary Aide. Dietary Aide #107 indicated that resident #006 and resident #007 left the dining room, saying they did not want to wait on their food.

Recreation Programmer #111 indicated that they assist in the B Wing dining room when they work mornings. Recreation Programmer #111 works full time but works four to six evenings per month so they would not be assisting in the B Wing dining room on those mornings. Recreation programmer #111 indicated that they are not replaced when they are off for holidays, and they are also off every third Friday and Monday because they work the weekend on those weeks. There would be nobody from Recreation to assist in the B Wing dining room for any of those mornings.

Restorative Care Worker #112 indicated that they work full time and assist in the B Wing dining room on weekday mornings, but they do not work every second Friday and Monday when they are scheduled to work weekends. They are not replaced on those mornings, nor are they replaced when they are off for holidays.

The Manager of Nutrition Services indicated to Inspector #178 that on the days when the Recreation Programmer and the Restorative Care Worker are not available to assist in the B Wing dining room, the RPN or PSWs should be assisting. However, some mornings neither the RPN or PSW is available to assist in the dining room. In those cases the Dietary Aide has been contacting the RPN who would contact the RN supervisor or Unit Manager to arrange for assistance in the dining room. The Manager of Nutrition Services was unaware of whether or not assistance was arranged in advance for the B Wing dining room on mornings when Restorative Care and Recreation workers are known to both have scheduled days off.

The Director of Care (DOC) indicated to inspector #178 that the RPN is supposed to assist in the B Wing dining room at breakfast as soon as they are able. The DOC also indicated that one PSW on B Wing is supposed to be assigned to assist in the dining room at 0800 or shortly thereafter, but if there are only two PSWs on the unit, this would be impossible. The DOC was unaware of any arrangements or plan in place to ensure that someone is available to assist in the B Wing dining room on mornings when the Recreation Programmer and Restorative Care Worker both have scheduled days off.

RPN #104 indicated that usually the Dietary Aide and Restorative Care Worker #112

assist residents in the B Wing dining room for breakfast, and the RPN assists as much as they are able, but the PSWs are unavailable to assist as they are busy getting the residents up from bed. RPN #104 indicated that they could call Recreation staff to assist as well, but on Fridays, there are no staff from Recreation or Restorative Care to assist with breakfast. RPN #104 indicated that on Fridays they are very busy attempting to serve drinks and food in the dining room and provide medications as well.

As such, the licensee has failed to ensure that the staffing plan for the program of personal support services provided for a staffing mix that is consistent with residents' assessed care and safety needs on B Wing, specifically with regards to preferred baths and timely assistance with breakfast when Restorative Care staff and Recreation staff are not available to assist. [s. 31. (3)]

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 staffing plan for the program of personal support services provides for a staffing mix that is consistent with residents' assessed care and safety needs, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002 received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening.

Resident #002 required total assistance with all activities of daily living. Review of resident #002's plan of care indicated that resident #002 required one person physical assist for oral care. Resident #002's plan of care further indicated that resident #002 will decline care related to cognitive impairment, and that when this happens, staff should allow the resident time to settle and re-approach after a specified length of time if safe. The plan of care indicated that resident #002 may need multiple attempts/re-attempts for care.

Progress notes indicated that the resident #002's oral hygiene was poor.

Family member #141 indicated to Inspector #178 that staff is not providing oral care to resident #002. Family member #141 indicated that they clean the resident's teeth once daily, and that staff is not providing oral care.

PSW #114 indicated that they attempt to provide oral care to resident #002 every day, but the resident sometimes refuses and prevents the staff from providing oral care. PSW #114 indicated that they do not re-approach resident #002 later to attempt to provide oral care, because the resident is not available for oral care later.

PSW #110 indicated that they attempt to provide oral care for resident #002 when they provide the resident's personal care, but the resident is not cooperative and prevents them from providing oral care. PSW #110 did not indicate that they re-approach the resident to re-attempt oral care, but indicated that resident #002 is provided oral care once daily from their family.

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 resident #002 receives oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, the plan was complied with.

In accordance with O.Reg. 79/10 s.31(3) the licensee was required to ensure that the staffing plan provided for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;

Specifically, the licensee did not comply with the licensee's nursing staffing plan (revised date September 2019) which is part of the licensee's nursing and personal support services program.

The licensee's staffing plan for B Wing (39 residents) was provided by the CEO to Inspector #178. Inspector #178 reviewed the staffing plan with the CEO and the staffing

plan indicated that on night shift, the minimum number of RPNs on B Wing is one, and the minimum number of PSWs on B Wing is one. The CEO indicated that if necessary, a PSW would be pulled from other units to work the shift on B Wing, which contains the most residents.

Family members #140 and #141 indicated to Inspector #178 that there have been nights when there was no PSW assigned to B wing. Family member #141 indicated that they were told by a staff member that their loved one had not received an identified element of required care during one night when there was no PSW assigned to B Wing.

RPN #105 indicated that on the night shift beginning at 2300 December 13, 2019, they were scheduled alone on 1B with no PSW, but a PSW was pulled from another unit between approximately 2310h and 0600h. RPN #105 further indicated that on the night shift beginning December 14, 2019, they worked alone on B Wing with no PSW scheduled during the shift. RPN #105 indicated that the Charge RN covered the unit for their breaks and they could have called the RN if they needed a second set of hands. RPN #105 indicated that they provided the care for the residents on B Wing alone that night, and two residents (resident #002 and #005) who required two persons to assist with an identified element of care, did not receive that care until the day staff came on at 0700h. The plans of care for resident #002 and resident #005, both required that the residents receive the identified element of care on rounds during the night. RPN #105 indicated that they have worked alone on B Wing at night in the past, but they have always had someone come over to assist with the rounds or be assigned to the unit for at least part of the night.

RPN #104 indicated that on night shift on an identified date, there was no PSW assigned to B Wing. RPN #102 indicated that a PSW came to the unit to assist with rounds from 0100h until 0300h, and a PSW came from another unit to assist with rounds from 0300h until 0400h. RPN #104 worked alone on the unit for the remainder of the shift.

RN Supervisor #136 indicated that when there has been no PSW available to work nights on B Wing, they either pulled a PSW from another unit to assist the RPN on B Wing for each of the two night rounds when residents are repositioned and their incontinent products are changed, or the RN Supervisor assisted with the change round themselves.

The CEO indicated that on night shift on an identified date, no PSW was scheduled for B wing, but PSWs from other areas in the home floated to B Wing to assist the RPN during

the night.

As such, the licensee did not comply with the licensee's nursing staffing plan (revised date September 2019) which is part of the licensee's nursing and personal support services program. [s. 8. (1) (b)]

Issued on this 13th day of January, 2020

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

Original report signed by the inspector.