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

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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 18, 2020	2020_593573_0004	023380-19, 023585-19, 001820-20	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

ANANDRAJ NATARAJAN (573)

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 06, 10, 11 and 12, 2020.

The following critical incident intake logs were inspected:
-Log #023380-19 regarding unknown cause of an injury to a resident for which the resident was taken to the hospital.
-Log #023585-19 related to staff to resident alleged abuse.
-Log #001820-20 related to a fall incident that caused an injury to a resident for which resident was transferred to hospital and resulted in significant change in the heath status.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers, Registered Practical Nurses, Registered Nurses, Unit Managers, Director of Care (DOC) and the Chief Executive Officer (CEO). In addition, the inspector reviewed resident health care records, observed the provision of care and services to residents, staff to resident interactions, and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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 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 the plan of care for resident #003 was provided to the resident as specified in the plan.

Resident #003’s health care record identified that the resident was at high risk for falls and had history of multiple falls. Resident #003’s written plan of care in effect included the use of a wheel chair tab alarm as one of the fall prevention interventions.

On February 12, 2020, Inspector #573 observed resident #003 sitting in a wheel chair without any wheel chair tab alarm attached to the resident. Inspector spoke with PSW #101, who indicated that they did not apply the wheel chair tab alarm for resident #003.

On February 12, 2020, during an interview RPN #102 they indicated that resident #003 was at high risk for falls. Further, RPN #102 stated that resident #003 recently had a fall incident that resulted in significant change in their heath status. RPN #102 reviewed resident #003’s current written plan of care in the presence of Inspector #573 and indicated that as per the plan of care the PSW staff were supposed to apply the wheel chair tab alarm for resident #003.

As such, the staff failed to ensure that the care set out in the plan of care for resident #003 was provided to the resident as specified in the plan, specifically related to the resident's fall prevention interventions.(Log #001820-20) [s. 6. (7)]

Issued on this 18th day of February, 2020

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

Original report signed by the inspector.