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

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
Sep 3, 2020	2020_770178_0007	005048-20, 005169-20, 013015-20, 013484-20, 013502-20	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): August 13, 14, 18, 19, 20, 21, 24, 2020.

The following Logs were inspected:
-#005169-20, #013015-20 (CIR #2702-000020-20), #013484-20 (CIR #2702-000021-20), and #013502-20 (CIR #2702-000022-20) regarding allegations of resident to resident abuse
-#005048-20 regarding concerns about resident care and sufficient staffing.

During the course of the inspection, the inspector(s) spoke with Chief Executive Officer (CEO), Nurse Managers, Community Nurse Coordinator, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Behavioural Support RPN and PSWs, Maintenance Assistant, Janitor, and Nutrition Manager.

During the course of the inspection, the inspector also observed the care of residents, reviewed resident health records and licensee records.

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

The responsive behaviour plan of care for resident #001 indicated that the resident exhibited responsive behaviours towards another resident, and instructed staff to take specific precautions when assisting resident #001.

PSW #112 indicated that on a day in March 2020, they assisted resident #001 without taking the precautions specified in resident #001's responsive behaviour plan of care. As a result, resident #001 exhibited responsive behaviour towards another resident. PSW #112 indicated that there had been no recent incidents of resident #001's responsive behaviours, so they thought the behaviour had resolved and did not follow the directions in resident #001's plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that staff and others who provide direct care to the resident were kept aware of the contents of the plan of care.

In July 2020, resident #001 exhibited responsive behaviour towards another resident. Three days later, resident #001's plan of care was revised to include an intervention to prevent resident #001 from exhibiting this responsive behaviour towards other residents.

In August 2020, PSW #106 indicated they were not aware of the intervention in place since July 2020, to prevent resident #001 from exhibiting responsive behaviours towards other residents. RPN #104 indicated that the staff had not been following the intervention that was added to resident #001's responsive behaviour plan of care in July 2020. RPN #104 indicated that they were not sure whether this intervention remained part of resident #001’s current plan of care.

In August 2020, Inspector #178 observed Nurse Coordinator #102 assisting resident #001 without following the intervention that was added to resident #001's responsive behaviour plan of care in July 2020. Nurse Coordinator #102 indicated to Inspector #178 that they were assisting with residents and had not been briefed regarding resident #001’s plan of care.

In August 2020, Nurse Manager #101 indicated that the intervention added to resident #001's responsive behaviour plan of care in July 2020 remains part of the resident's plan

of care, and the staff should be following this intervention when assisting resident #001. [s. 6. (8)]

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 staff and others who provide direct care to resident #001 are kept aware of the contents of the plan of care, and that care set out in the plan of care is provided to resident #001 as specified in the plan, to be implemented voluntarily.

Issued on this 16th day of September, 2020

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

Original report signed by the inspector.