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
Mar 19, 2021	2021_785732_0005	002937-21, 002985-21, 003003-21, 003767-21	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

EMILY PRIOR (732)

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): March 1 to 5 and 8 to 11, 2021

The following logs were inspected in this Complaint inspection:

Log #002937-21 and log #003003-21 with concerns related to COVID-19 directives, infection prevention and control (IPAC) measures, and dining;

Log #002985-21 related to visitation; and

Log #003767-21 related to skin and wound, continence care, personal support services, and staffing.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer, the Director of Care (DOC), a Unit Manager, the Community Services Manager, the Community Nursing Coordinator and IPAC lead, Registered Practical Nurses (RPN), Personal Support Workers (PSW), a Recreation Programmer, and a housekeeper.

In addition, the inspector(s) reviewed resident health care records and relevant policies and procedure; as well as observed the provision of care and services to residents, resident care areas, breakfast and dinner meal service, and IPAC measures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
2 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident’s written plan of care set out clear directions to staff and others who provide direct care to the resident.

A complaint was made to the Director that expressed concern over a resident’s transfer sling being left under the resident while up in their chair. A PSW confirmed with Inspector #732 that staff had been leaving the transfer sling under the resident as was indicated by a document behind the nursing desk. An RPN described that if a transfer sling is to be left under a resident it should be indicated in that resident’s plan of care. The RPN went on to describe that the resident’s plan of care did not indicate to leave the transfer sling under the resident and therefore had staff remove it. A different RPN told Inspector #732 that restorative care is to do an assessment to determine if it is appropriate to leave a transfer sling under a resident and that they would then add this to the plan of care as well as inform the staff and power of attorney (POA). Both RPN's indicated that a request for assessment had been sent to restorative care to reassess the resident.

A progress note written by another RPN described that they sent an email to the Unit Manager and Occupational Therapist (OT) four days earlier. OT responded by acknowledging that the complainant's concerns are valid, but as per policy, sling is to be left in place. The RPN mentioned that this information was not indicated in the care plan, therefore an assessment should be completed to determine appropriateness. The RPN also noted that they were unable to locate any past assessment. In conclusion, the resident’s written plan of care did not provide clear direction to staff on whether to leave the transfer sling under the resident while up in their chair or whether to remove it.

Sources: Resident's health care record; and interviews with a PSW, the Unit Manager, and RPN's. [s. 6. (1) (c)]

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 written plan of care sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the monitoring of all residents occurred during meals.

Residents are currently receiving tray service in their rooms for all meals. The Unit manager confirmed that residents eating in their room should be monitored and checked on. They further explained that generally one staff is supposed to be free, walking around monitoring, while the other staff are feeding those residents who require assistance. The DOC explained that not all staff should be in resident rooms feeding and that someone should be out doing a supervision round, peaking their head in, and checking in on residents.

Inspector #732 observed numerous dining services, on two separate units, from March 1 to 3, 2021 and March 8 to 11, 2021. Monitoring of residents was not occurring as described on any of the above dates. As a result of lack of monitoring, there was risk of harm to resident’s health and safety.

Sources: Interview with Unit Manager; Director of Care, and other staff; and dining observations. [s. 73. (1) 4.]

2. The licensee has failed to ensure that three residents were not served a meal before someone was available to assist them.

Residents are currently receiving tray service in their rooms for all meals. All three resident's plans of care indicated that they required assistance for eating; specifically, one person physical assist. On March 10, 2021, a resident was observed in their room, with their meal tray, and no staff available to assist. The next day, the two other residents were observed in their rooms, with their meal trays, and no staff available to assist. As all three residents require physical assistance with eating, there was risk of harm to the residents as their meal tray was provided to them before assistance of staff was available.

Sources: Dining observations; and resident's plans of care. [s. 73. (2) (b)]

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 all residents are monitored during meals and that those residents who require assistance with eating are not served a meal until someone is available to assist them, to be implemented voluntarily.

WN #3: 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 the “Wound Assessments” policy and procedure included in the required skin and wound care program was complied with for a resident.

O. Reg 79/10, s.48(1) requires the licensee of a LTCH to ensure that a skin and wound program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions is developed and implemented in the home.

O. Reg 79/10, s.30 requires that each of the interdisciplinary programs required under section 48 of the regulation includes relevant policies, procedures and protocols.

Specifically, staff did not comply with the licensee’s policy and procedure “Wound Assessments”.

An area of altered skin integrity was identified on a resident in February, 2021, by an RPN. The licensee’s “Wound Assessments” procedure described that the RPN will inform the resident or POA or SDM regarding any new skin issues and note this with a date at the bottom of the wound assessment. The RPN told Inspector #732 that they did not notify the POA the day they discovered the altered skin integrity but did when the POA was on the floor, a few days later. Progress notes were reviewed and revealed that the POA was not made aware of the altered skin integrity until five days after it was discovered.

Sources: Resident's health care record; "Wound Assessments" policy and procedure; conversation with complainant; and interview with an RPN, and other staff. [s. 8. (1) (a),s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident received a skin assessment, using a clinically appropriate assessment instrument, when altered skin integrity was identified.

An area of altered skin integrity was identified on a resident in February, 2021. The licensee's "Skin Integrity and Wound Care Policy and Procedure", and "Skin Assessment" policy and procedure, described that residents with signs of altered skin integrity will have a wound assessment completed under the assessment tab in Point Click Care (PCC). It further described that if the area of skin breakdown is new, document a skin assessment under Initial Wound Assessment, and if area of skin breakdown is an existing area, complete the Weekly Wound Assessment. This was confirmed by two RPN's and the Unit Manager.

Inspector #732 reviewed PCC and was unable to locate an Initial Wound Assessment or Weekly Wound Assessment on the day the altered skin integrity was discovered for the resident, which was confirmed by an RPN .

Sources: Resident's health care record; "Wound Assessments" policy and procedure; "Skin Integrity and Wound Care Policy and Procedure"; and interview with RPN's and the Unit Manager. [s. 50. (2) (b) (i)]

Issued on this 24th day of March, 2021

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

Original report signed by the inspector.