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 30, 2022	2022_770178_0006	017574-21	Follow up

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 Follow up inspection.

This inspection was conducted on the following date(s): March 22-25, 2022.

The following intake was completed in this Follow Up Inspection:
Log #017574-21 was related to Skin and Wound Care.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer, Director of Care, Infection Prevention and Control Lead, Skin and Wound Care Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Covid-19 Tester, and Housekeeper.

During the course of this inspection, the inspector observed infection prevention and control practices, meal service, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 8. (1)	CO #001	2021_770178_0020	178

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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under the Skin and Wound Care program, including interventions were documented.

Scheduled wound treatments for a resident were not documented in the resident's record on four different dates. The Director of Care (DOC) indicated that when staff provides scheduled wound treatments, they document them by initialing the resident's electronic Treatment Administration Record (eTAR). Interviews with Registered Nursing staff indicated that the resident's wound treatments were provided, but no documentation of the above noted wound treatments was found in the resident's clinical health record.

Sources: A resident's clinical health record; and interviews with an RN, the DOC, and other staff. [s. 30. (2)]

2. A resident was scheduled to have a cream applied twice daily. Interviews with Registered Nursing staff indicated that the scheduled treatments were provided. However, one half of the scheduled applications during a month were not initialed on the resident's eTAR or documented elsewhere in the resident's clinical health record.

Sources: A resident's clinical health record: and interviews with an RN, the DOC and other staff.

Failure to document the residents' wound care posed a risk of harm by hindering accurate communication regarding the residents' care. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee's Infection Prevention and Control (IPAC) program was followed by staff in accordance with evidence-based practices, specifically related to assisting residents to perform hand hygiene before and after meals.

Evidence-based practice indicates that staff should assist residents to perform hand hygiene before and after meals. Observations of a lunch meal service in the auditorium dining room revealed residents' hands were not cleaned before or after the meal service. The IPAC Lead and a PSW indicated that it is the responsibility of the staff assisting with meal service to ensure that residents hands are cleaned before and after meals, on entering and exiting the dining room.

Lack of hand hygiene increases the risk of disease transmission among residents and staff.

Sources: Public Health Ontario-Best Practices for Hand Hygiene in all Health Care Settings, 4th
edition (April 2014); observation of meal service; interview with the IPAC Lead and other staff. [s. 229. (4)]

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 licensee's Infection Prevention and Control program is followed by staff in accordance with evidence-based practices, specifically related to assisting residents to perform hand hygiene before and after meals, to be implemented voluntarily.

Issued on this 30th day of March, 2022

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

Original report signed by the inspector.