Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: March 17, 2023

Inspection Number: 2023-1201-0002

Inspection Type:
Complaint
Critical Incident System

Licensee: Marianhill Inc.

Long Term Care Home and City: Marianhill Nursing Home, Pembroke

Lead Inspector	**Inspector Digital Signature**
Karen Buness (720483)	Karen Lynne Buness Digitally signed by Karen Lynne Buness Date: 2023.03.29 09:56:05 -04'00'
Additional Inspector(s) Emily Prior (732)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 13, 14, 15, 16, 17, 21, 22, 23, 24, 27, 28, March 1, 2023

The following intake(s) were inspected:

- Intake: #00014035-Complaint related to resident's plan of care and falls prevention and management.
- Intake: #00016658-Complaint related to resident's plan of care verbal abuse by staff and availability of supplies.
- Intake: #00017119-Complaint related to resident safety.
- Intake: #00018171 -Complaint related to neglect of residents.
- Intake: #00019024 -A fall which resulted in transfer to hospital and a significant change in condition.
- Intake: #00020285- Unexpected death of resident.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 34 (3)

The Licensee has failed to ensure that the falls prevention and management program was evaluated and updated at least annually, in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Rationale and Summary
Inspector reviewed the Licensee's falls prevention and management program titled Interdisciplinary Falls Prevention and Management Program Nursing Policy/Procedure Manual. Upon review of the program, it was noted that it was last revised in December of 2019. The DOC acknowledged the date and confirmed that it had not been revised or updated since then.

Prior to the completion of the inspection, the DOC provided Inspector with an updated Interdisciplinary Falls Prevention and Management Program Nursing Policy/Procedure Manual. The revised date of the program was February of 2023.

Sources: Interdisciplinary Falls Prevention and Management Program Nursing Policy/Procedure Manual, revised 12-2019; Interdisciplinary Falls Prevention and Management Program Nursing Policy/Procedure Manual, revised 02-2023; and interview with DOC.

Date Remedy Implemented: February 21, 2023.

[732]

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The Licensee has failed to ensure that the written plan of care for resident #002 set out clear direction to staff in regard to the resident's code status.

Rationale and Summary
Resident #002 required medical services. The Registered Practical Nurse requested the resident's code status from the Registered Nurse, however, the code status could not be found in the resident's paper clinical record or electronic clinical record. This caused a delay in obtaining the information.
The DOC explained that a resident's code status should be documented in the electronic clinical record. In error the resident's code status was not entered properly in the system.

Due to resident #002's code status, the failure to provide clear direction to staff regarding the resident's code status did not increase the risk of harm to the resident.

Sources: Resident #002's clinical record; Critical Incident Report and interviews with DOC and Registered Staff.

[732]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The Licensee has failed to ensure that resident #001's wheelchair was tilted as per their plan of care.

Rationale and Summary

Resident #001's plan of care indicated to keep resident tilted in wheelchair in room if alone.

On a specified date, resident #001 had an unwitnessed fall from their wheelchair, resulting in injury and required transfer to hospital. The registered staff indicated that at the time of the fall, the resident's chair was in the sitting position, and was not tilted back.

The failure to ensure resident #001 was tilted in their wheelchair impacted the resident as they suffered a fall which resulted in an injury and transfer to hospital.

Sources: Resident #001's clinical record and interviews with staff.

[732]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The Licensee has failed to ensure that resident #001's lap belt was applied as per their plan of care.

Rationale and Summary
Resident #001's plan of care indicated that a lap belt restraint be in use while up in wheelchair for safety and positioning.

On a specified date, resident #001's POA visited the resident in their room and noted that the lap belt was not applied. Staff confirmed that they had not applied the lap belt that morning.

As the lap belt had not been applied while the resident was up in the chair, there was risk of harm to resident #001 as a fall and/or injury could have resulted.

Sources: Resident #001's clinical record and interviews with staff.

[732]

WRITTEN NOTIFICATION: Required Programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 53 (1) 1.

The Licensee has failed to ensure that the falls prevention and management program regarding risk management incident reports was complied with.

In accordance with O.Reg 246/22 s. 53(1)1, the Licensee shall ensure that a falls prevention and management program is developed and implemented in the home to reduce the incidence of falls and the risk of injury, and O. Reg246/22 s.11(1)(b) requires that the program be complied with.

Specifically, the Licensee has failed to ensure that a risk management incident report was completed after resident #001's fall as indicated in the Licensee's Falls Prevention and Management Program Nursing Policy/Procedure Manual.

Rationale and Summary

On a specified date, resident #001 had an unwitnessed fall resulting in injury and requiring transfer to hospital. As per the Licensee's Falls Prevention and Management Program Nursing Policy/Procedure Manual, an RPN, RN, or Unit Manager should complete a risk management incident report after a resident has fallen. Inspector reviewed resident #001's clinical records and was unable to locate a risk management incident report for the fall. DOC confirmed that a risk management incident report should have been completed after the resident's fall, and that one had not been completed.

Failure to complete the risk management incident report increased the potential risk of harm to the resident. The use of the incident report may have assisted staff to better identify the cause of the resident's fall, as well as aided in developing effective fall prevention measures to prevent future falls.

Sources: resident #001's clinical record; Interdisciplinary Falls Prevention and Management Program Nursing Policy/Procedure Manual, revised 12-2019; and interview with DOC and other staff.

[732]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 54 (2)

The Licensee has failed to ensure that a post fall assessment, using a clinically appropriate assessment instrument specifically designed for falls, was completed after resident #001 experienced a fall.

This NC is documented in inspection report #2023-1201-0003.

[732]

WRITTEN NOTIFICATION: Continence Care and Bowel Managment

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 56 (2) (a)

The Licensee has failed to ensure that resident #004 received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

Rationale and Summary
The DOC explained that residents should be assessed for incontinence on admission, and quarterly thereafter. They explained that the assessment is the Continence and Constipation Assessment.

According to staff and management, resident #004 could be incontinent at times and required incontinence products. Upon review of resident #004's clinical record, inspector noted no incontinence assessment completed; and the Continence and Constipation Assessment specified 75 days overdue. The DOC confirmed that resident #004 had not received an incontinence assessment on admission, nor had they received one at anytime while admitted to the home.

Failure to ensure resident #004 was assessed for incontinence resulted in moderate risk of harm to the resident as identification of factors, patterns, types of incontinence, potential to restore function, and type of product were not assessed. This could have affected the resident's ability to manage and promote bladder continence.

Sources: resident #004's health care record; Interview with DOC #103 and other staff.

[732]

COMPLIANCE ORDER CO #001 Infection Prevention and Control

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

A. Educate all PSW staff working on the unit specified including Full Time, Part Time and on a casual basis on resident and staff hand hygiene as per evidence based best practice standards.
B. Perform weekly hand hygiene audits to ensure that staff are following the licensee's Infection and Prevention Program. Audits are to be conducted until consistent compliance to the Infection and Prevention Program described above is demonstrated.
C. Take corrective actions to address staff non-compliance related to hand hygiene as identified in the audits.
D. Written records of A, B and C shall be maintained until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

Rationale and Summary

Observations:
On a specific date and time the lunch dining service on a resident care unit was observed.
3 PSWs escorted 18 residents into the dining room. Of the 18 residents 0 residents received prompting or physical assistance with handwashing upon entering the dining room or prior to being provided their meal. 6 residents entered the dining room independently. Of the 6 residents 1 resident was observed independently washing his hands using ABHR. The remaining 5 residents did not receive prompting or assistance with hand hygiene.
Throughout the meal service all 3 PSWs moved throughout the dining room handing out drinks, food and cleaning up dirty dishes without performing hand hygiene.
A PSW served 27 residents beverages off the drink cart without performing hand hygiene before initiating the task, between residents or upon completing the task. The same PSW then assisted a resident with their meal and did not perform hand hygiene before or after the task.
An additional PSW was observed physically assisting 2 residents with their meal but did not perform hand hygiene prior to commencing, in between residents or after the task was complete.
During an additional observation 2 PSW staff members porter residents from the dining room to their rooms.
Both PSW staff members were observed to not perform hand hygiene prior to entering the room, assisting residents in their rooms, or upon exiting the rooms.

Interviews:

-PSW#104 stated staff were required to perform resident hand hygiene before and after meals. PSW #104 also stated staff are required to perform personal hand hygiene during meal service, when picking up dirty dishes and in between assisting residents with eating.
On February 14, 2023, PSW #105 reported staff were to assist residents with hand hygiene before and after meals and personal hand hygiene after contact with a resident, prior to helping a different resident.
-RPN #122 reported staff are required to wash resident's hands before eating, before taking medications and after using the washroom.
-The IPAC Lead confirmed staff are to wash the resident’s hands before and after meals.

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

Sources: Sources: Public Health Ontario - Best Practices for Hand Hygiene in All Health Care Settings, 4thEdition (April 2014), observation of lunch service and care provision, and interview with Registered Staff, Personal Support Workers and the IPAC Lead.

[720483]

This order must be complied with by April 27, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.