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
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Original Public Report

Report Issue Date: March 17, 2023	
Inspection Number: 2023-1201-0003	
Inspection Type: Complaint	
Licensee: Marianhill Inc.	
Long Term Care Home and City: Marianhill Nursing Home, Pembroke	
Lead Inspector Karen Buness (720483)	**Inspector Digital Signature** Karen Lynne Buness Digitally signed by Karen Lynne Buness Date: 2023.03.30 11:31:51 -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: #00016697- Complaint related to resident care and services

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

Resident Care and Support Services
Food, Nutrition and Hydration
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #001 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 a resident experiences a fall.

Rationale and Summary:
On a specific date, resident #002 was found in the washroom on the floor. The licensee's Falls Prevention and Management Program Nursing Policy/Procedure Manual states when a resident has fallen, the resident will be assessed. When the condition or circumstances of the resident require, a post-fall assessment will be conducted using the post fall assessment tool. Unit Manager stated the assessment includes the resident's risk of falls, and level of injury. If the resident is assessed as a low falls risk a post fall assessment does not need to be completed. A review of resident #002's Falls Risk Assessment completed on admission deemed the resident a high risk for falls. Inspector could not locate a post falls assessment in the resident's clinical record. Unit manager confirmed a post falls assessment had not been done.

Sources:
Resident #002's electronic clinical record, Falls Prevention and Management Program Nursing Policy/Procedure Manual, revised 12-2019, interview with unit manager.

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Non compliance from Inspection 2021-1201-0002
Rationale and Summary:
On a specified date, resident #001 had an unwitnessed fall, resulting in injury and transfer to hospital. After review of resident #001's health care records, Inspector was unable to locate a Post Fall Assessment Tool completed for resident #001's fall. DOC confirmed with Inspector that a post fall assessment should have been done using the Post Fall Assessment Tool and that one had not been completed upon review of resident #001's chart.

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

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Impact/Risk:
Failure to complete the Post Fall Assessment Tool increases the potential risk of harm to the resident. The use of the tool 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.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee failed to ensure that the resident, the resident's substitute decision-maker SDM, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary:
Resident #002 required treatment in order to be fit for new hearing aides. Resident #002 was without hearing aides at the time which significantly impacted their ability to communicate with others and participate in care. Treatment was order by the physician, but the licensee did not notify the SDM that the treatment had been completed and the resident could be fit for hearing aides until the SDM voiced concerns of the failure to complete the treatment and the resulting impact on the resident's quality of life. Interview with unit manager #100 confirmed the SDM was not notified until after the family voiced concerns.

Impact/Risk:
Failure to notify the SDM the resident's ear wax build up had resolved delayed the resident being fit for hearing aides which decreased the resident's quality of life.

Sources:
Resident #002's electronic clinical record, interview with unit manager, registered staff and resident's SDM.

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