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: June 19, 2023	
Inspection Number: 2023-1201-0005	
Inspection Type: Complaint	
Licensee: Marianhill Inc.	
Long Term Care Home and City: Marianhill Nursing Home, Pembroke	
Lead Inspector Severn Brown (740785)	**Inspector Digital Signature** Severn Brown Digitally signed by Severn Brown Date: 2023.06.19 14:08:53 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 15, 16, 17, 18, 23, 24, 25, 26, 29, 30, 2023
The inspection occurred offsite on the following date(s): May 31, 2023

The following intake(s) were inspected:

- Intake: #00020822 - Complainant has concerns regarding resident about the following: weight changes, laundry service, mobility device, swallowing, medication changes, and plan of care.

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

Resident Care and Support Services
Continence Care
Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that care set out in the plan of care was provided as specified in the plan. Specifically, the licensee failed to ensure that a resident was provided physiotherapy at the frequency specified in their plan of care.

Rationale and summary
The resident's plan of care specifies that they are to receive physiotherapy from a Physiotherapist (PT) or Physiotherapy Assistant (PTA) at a prescribed frequency. Upon review of the resident medical record, no physiotherapy documentation was found for a prolonged period of time. A PT stated that any treatment provided by a PT or PTA must be documented in the resident's medical record. The PT stated that the home had little or no access to PTAs for an extended period of time and that residents did not have full access to physiotherapy during this time. The Manager of Recreation and Volunteers confirmed that the home did not have access to PTAs during an extended period and they likely missed physiotherapy due to staffing shortages.

By not ensuring that resident was provided physiotherapy as specified in their plan of care, the resident was placed at an increased risk of deterioration in their ability to mobilize and ambulate.

Sources:
Interviews with a PT and the Manager of Recreation and Volunteers;
The Resident's medical record.

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WRITTEN NOTIFICATION: Oral care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 38 (1) (a)

The licensee failed to ensure that a resident received morning oral care on specific dates.

Rationale and summary
The resident's family member brought forward a concern regarding documentation for the resident regarding the status of poor oral hygiene. A Registered Dental Hygienist (RDH) documented that the resident's oral hygiene was quite poor on assessment. In reviewing the resident's oral care documentation, it was determined that no oral care was provided to the resident on the mornings of specific dates. The RDH confirmed that the resident's oral status was very poor when they provided care for the resident. A PSW who documented on the resident's oral care on the specified dates confirmed they were unable to perform oral care to resident during those specific shifts. The Unit Manager and the PSW both stated that residents are to receive oral care each morning and evening.

By not ensuring that the resident received oral care on the mornings of the specified dates, the resident was placed at increased risk for poor oral health.

Sources
Interviews with a PSW, an RDH, and a Unit Manager;
The Resident's medical record

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WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that a resident was reassessed weekly by a member of the registered nursing staff for their exhibited altered skin integrity.

Rationale and Summary
The resident began to exhibit altered skin integrity and was later assessed to have developed further

skin impairment.

Upon review of the resident's medical record, no reassessment of the resident's altered skin integrity was documented at the legislatively required weekly interval for one specified week. An RPN documented during the week without a skin assessment that they were unable to perform a skin reassessment.

A Unit Manager stated that resident required weekly skin reassessments after developing impaired skin integrity. Upon record review with the Unit Manager present, it was confirmed that no documentation of a skin reassessment of the resident was completed during one specific week.

By not ensuring that a weekly skin reassessment for altered skin integrity was performed, the resident was placed at increased risk of unresolved skin integrity impairment and further complications from the skin impairment.

Sources
The resident's medical record.
Interview a Unit Manager.

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WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (e) (i)

The licensee failed to comply with the home's weight monitoring system to ensure that a resident was weighed monthly.

Rationale and summary
During an interview with the Registered Dietitian (RD), it was identified by the interviewee that no weight was recorded in a specific month. RD and a Registered Practical Nurse (RPN) stated that residents are to be weighed on a monthly basis. The RD stated that the resident was moved to a different unit during that same month and this may have been the reason that a weight was not measured.

The resident's weight record in their medical record contains no weight for a specified month. The

resident's care plan states they are at a high nutritional risk.

By not ensuring that the resident was weighed during a specific month, the resident was placed at increased risk of having an unidentified change in their weight.

Sources
The resident's medical record and plan of care
Interviews with an RD and RPN.

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WRITTEN NOTIFICATION: Dealing with complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

The licensee failed to ensure that, for a written complaint made to the licensee concerning the care of a resident, a response that complies with O. Reg 246/22 s. 108 (1) 3. was provided to the complainant.

Rationale and summary
A written complaint was submitted to the home from a resident's family member on a specific date regarding the resident's care. This complaint was also submitted to the Director by the complainant. The complainant alleged that no response was provided by the home regarding this complaint. The written complaint submitted by the complainant to the Director regarding the care of a resident did not contain a response letter from the home.

In an interview with the Administrator, they acknowledged that they received the complaint regarding the care of a resident but never provided a response to the complainant.

Sources:
Complaint submitted to the Director;
Interview with the Administrator.

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