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

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Original Public Report

Report Issue Date: May 23, 2024	
Inspection Number: 2024-1201-0002	
Inspection Type: Critical Incident	
Licensee: Marianhill Inc.	
Long Term Care Home and City: Marianhill Nursing Home, Pembroke	
Lead Inspector Dee Colborne (000721)	**Inspector Digital Signature** Diana (Dee) Colborne Digitally signed by Diana (Dee) Colborne Date: 2024.05.27 08:50:03 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 14, 15, 16, 17, 2024

The following intake(s) were inspected:

- Intake: #00115016 - Complaint of a resident in regards to neglect of care.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Reporting and Complaints
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 29 (4) (a)

Plan of care

s. 29 (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,

(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and

The licensee has failed to ensure that a complete nutritional assessment is completed for all residents on admission. Specifically the licensee failed to complete a nutritional assessment on a resident upon admission.

Rationale and Summary:

Inspector reviewed the nutrition referral to the Registered Dietitian (RD), that was sent by the RPN on a specified date in April 2024 and noted it was was not completed for the resident.

Inspector reviewed the food and fluid intake of a resident from the time they were admitted on a specified date in April 2024 to their death on a specified date in May 2024 and noted that their food and fluid intake was below the requirements.

Review of the resident's progress notes, identified that on a specified date in April 2024, the RPN sent another referral to the RD to assess the resident related to swallowing issues and to obtain a supplement order. It was noted that the RD

conducted a feeding assessment on a specified date in April 2024, ordered supplements and a change in the resident's diet texture. No other nutritional assessment was conducted.

During an interview with an RPN and PSW, they confirmed that the resident had poor food and fluid intake since admission.
During an interview with the RD, they confirmed that they did not complete the admission nutritional assessment, but did complete a feeding assessment on a specified date in April 2024.
During an interview with the DOC on a specified date in May 2024, they confirmed that the homes expectation is for the RD to complete the admission nutritional assessment in the first week of admission.

Failure to ensure that a nutritional assessment is completed on admission, increases the risk for residents not having appropriate nutritional interventions.

Sources: Resident's progress notes, nutritional assessment referral form, food and fluid intakes, interview with RPN, RD, DOC and other staff.
[000721]

WRITTEN NOTIFICATION: General requirements

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
3. The program must be evaluated and updated at least annually in accordance

with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee has failed to ensure that the hydration program be updated at least annually in accordance with evidence-based practices. Specifically the licensee has failed to update their policy annually, titled "Fluid Watch Program", which was last updated November 2020.

Rationale and Summary:
During a record review of the homes policy titled "Fluid Watch Program" in the Nursing manual under the risk management section of the homes policies, identified that the effective date of the policy was November 2020 and there was no revised date noted on the document.

During an interview with the Manager of Nutritional Services/Interim Manager of Environmental Services on a specified date in May 2024, they confirmed that the Fluid Watch Program has not been updated since November 2020.
During an interview with the Administrator on a specified date in May 2024, they confirmed that the homes expectation is to ensure policies are updated on an annual basis.

Failure to update programs on an annual basis, increases the risk of the home not following evidence- based practices.

Sources: Homes Fluid Watch Program policy dated November 2020 in the Nursing manual under risk management section, Interviews with Manger of Nutritional Services/Interim Manager of Environmental Services and the Administrator. [000721]

WRITTEN NOTIFICATION: Bathing

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 37 (1)

Bathing

s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that each resident of the home is bathed, at minimum, twice a week by a method of their choice. Specifically, a resident did not receive a bath twice a week.

Rationale and Summary:

Review of a resident's written plan of care in regards to bathing specifies that the resident is to have assistance of staff with bathing twice a week on specified days of the week during day shift.

Review of the resident's documentation for bathing task, was not signed off as being completed on two specific dates in April 2024 and May 2024.

During an interview with a Personal Support Worker (PSW), on a specified date in May 2024, they confirmed the resident was to have two baths per week.

During an interview with the Director of Care (DOC) on a specified date in May 2024, they confirmed that the resident did not have their bath on two specific dates in April 2024 and May 2024.

Failure to ensure that the written plan of care is complied with a resident receiving a bath, increases the risk of the resident not being in a clean state.

Sources: Resident's written plan of care, bath documentation, interview with PSW and the DOC.
[000721]

WRITTEN NOTIFICATION: Attending Physician

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 88 (1) (a)
Attending physician or RN (EC)
s. 88 (1) Every licensee of a long-term care home shall ensure that either a physician or a registered nurse in the extended class,
(a) conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination;

The licensee has failed to ensure that a physical examination of each resident upon admission is conducted and that a written report of the findings of the examination is produced. Specifically, there was no physical examination conducted for a resident upon their admission.

Rationale and Summary:
Inspector reviewed a resident's physical chart on a specified date in May 2024 and was unable to find an admission physical examination conducted by a physician. Upon review of the resident's progress notes, there was an entry from the physician on a specified date in May 2024, a day after the resident had passed away, indicating that the physician and the nurse manager had a discussion about the resident on a specified date in April 2024, but there was nothing documented in regards to them performing a physical assessment.

During an interview with the DOC on a specified date in May 2024, they confirmed

that the physicians should complete the physical assessment within a week of the admission, and that the physician did have a clinic day on a specified date in April 2024. They confirmed that the physician would make a written note in the progress notes of their physical assessment and confirmed it wasn't there.

Failure to ensure a physical assessment is conducted upon admission, delays the time for appropriate interventions to be in place for the resident.

Sources: Resident's chart, progress notes and interview with the DOC.
[000721]

WRITTEN NOTIFICATION: IPAC

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

1) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control is followed. Specifically, as per the IPAC standard for Long-Term care homes additional requirement, 2.1, the home did not conduct real-time audits in regard to the selection, donning and doffing of PPE by staff on a quarterly basis.

Rationale and Summary:
During a review of the homes PPE audits, the inspector identified that audits for the selection, donning and doffing of PPE on staff, were only completed on five occasions, one of which was in 2021 and the other four in the year 2022. There were

no audits conducted since that time.

During an interview with the IPAC lead, they confirmed they have not conducted them on a quarterly basis.

During an interview with the DOC, they confirmed the homes expectation for the IPAC lead would be to conduct any audits as required by the IPAC standard.

Failure to conduct PPE audits on staff, increases the risk of staff not following appropriate infection control precautions.

Sources: Review of homes IPAC audits, interview with IPAC Lead and DOC [000721]

2) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control is followed. Specifically, as per the IPAC standard for Long-Term care homes additional requirement, 7.3 (b), the home did not conduct audits on a quarterly basis to ensure that all staff can perform the IPAC skills required of their role.

Rationale and Summary:
During a review of the homes audits, there were three audits noted in regards to auditing staff to ensure they are able to perform IPAC skills pertinent to their role. Two of which occurred in February of 2022 and one in July 2023.

During an interview with the IPAC lead, they confirmed they have not conducted any audits on staff performing their IPAC skills training on a quarterly basis.

During an interview with the DOC, they confirmed the homes expectation for the

IPAC lead would be to conduct any audits as required by the IPAC standard.

Failure to conduct audits on staff to ensure they are able to perform IPAC skills pertinent to their role, increases the risk of staff not following appropriate infection control precautions.

Sources: Review of homes IPAC audits, interviews with the IPAC lead and DOC. [000721]

WRITTEN NOTIFICATION: Notification re: incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (2)
Notification re incidents
s. 104 (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

The licensee has failed to ensure that the substitute decision maker was notified of the results of an alleged neglect investigation. Specifically, the substitute decision maker for a resident, was not notified of the results of the alleged neglect investigation.

Rationale and Summary:
Record review of the homes investigation notes in regards to the alleged neglect of a resident, do not identify where the substitute decision maker (SDM) was notified of the results of the investigation.
Record review of the resident's progress notes do not identify where the SDM of the resident was notified of the results of the neglect investigation.

During an interview with the SDM on a specified date in May 2024, they confirmed they were not notified of the outcome of the neglect allegations.
During an interview with the DOC on a specified date in May 2024, they confirmed that the SDM was not notified of the results of the alleged neglect investigation.

Failure to inform the SDM of the results of an alleged neglect investigation impacts the relationship between the resident and the home.

Sources: Homes investigation notes, resident's progress notes, interviews with the SDM and DOC.
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WRITTEN NOTIFICATION: Reports re: critical incidents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

The licensee has failed to report an unexpected or sudden death to the Director. Specifically, the licensee did not report the sudden death of a resident.

Rationale and Summary:
Review of a resident's progress notes identify that the resident was cold to touch, drooling to right side of mouth, vital signs absent and was found upright in their

wheelchair on a specified date and time in May 2024. They were pronounced deceased.
Review of the resident's death certificate signed by the coroner, indicated cause of death as sudden.
During a review of the LTChomes.net critical incident(CI) reporting portal, it was identified that there was no critical Incident submitted by the home to report the sudden death of the resident.

Interview with the DOC on a specified date in May 2024, confirmed they did not report the unexpected death to the Director.

Failure to report an unexpected or sudden death to the Director, delays the timeliness in appropriate follow up and investigation.

Sources: Resident's progress notes and death certificate, LTChomes.net portal, interview with the DOC.
[000721]