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 410
Ottawa, ON, K1S 3J4
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Original Public Report

Report Issue Date: October 22, 2024
Inspection Number: 2024-1201-0005
Inspection Type: Complaint Critical Incident
Licensee: Marianhill Inc.
Long Term Care Home and City: Marianhill Nursing Home, Pembroke

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 16, 17, 18, 21, 22, 2024

The following intake(s) were inspected:

- Intake: #00120907 - Unexpected death of a resident
- Intake: #00121612 - Complainant with care concerns regarding a resident
- Intake: #00123002 - Unexpected death of a resident

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control

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 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that a resident's written plan of care identifies individualized interventions required in regards to their skin integrity. Specifically, there were no specific skin integrity focus on a resident's written plan of care outlining what interventions were required to promote healing of the residents skin breakdown.

Sources: Resident's clinical record, Homes skin and wound policy, Interviews with an RPN, PSW, Unit Manager and ADOC.

WRITTEN NOTIFICATION: Plan of Care-Pain

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 29 (3) 10.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs.

The licensee has failed to ensure that an interdisciplinary assessment was completed on a resident and added to to their plan of care, in regards to pain after a

significant injury on a specified dated in June 2024.

Sources: Resident' progress notes, care plan, eMAR, assessments, physician orders, Homes policy titled "Assessment and Management of Pain" Interview with an RPN and unit manager.

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to comply with the home's falls prevention and management policy related to the head injury assessment included in the required falls prevention and management program in the home, for a resident.

In accordance with O. Reg 246 / 22 s. 11 (1) b, the licensee is required to ensure that written policies and protocols were developed for the falls prevention and management program and ensure they were complied with.

Specifically, staff did not comply with the licensee's "Interdisciplinary Falls prevention management program " policy revised October 2023 when they did not complete the head injury assessment in its entirety for a resident after a significant injury.

Sources: Resident's head injury assessment, homes policy titled " Head Injury Assessment", interviews with an RPN, unit manager and other staff.

WRITTEN NOTIFICATION: Skin and Wound

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 53 (1) 2.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions.

The licensee has failed to comply with the home's skin and wound policy related to referrals to be made to the Physiotherapy (PT) or Occupational Therapy (OT) for assessment included in the required skin and wound care program in the home, for a resident.

In accordance with O. Reg 246 / 22 s. 11 (1) b, the licensee is required to ensure that written policies and protocols were developed for the skin and wound program and ensure they were complied with.

Specifically, staff did not comply with the licensee's "Skin Integrity and Wound Care with Mobile App Policy and Procedure" revised May 2023 when they did not refer to PT and OT for a resident's poor skin integrity.

Sources: Resident's clinical record, Homes policy titled " Skin Integrity and Wound Care with Mobile App Policy and Procedure, interviews with a PSW, RPN and Assistant Director of Care (ADOC).

WRITTEN NOTIFICATION: Reporting of Critical Incidents

NC #005 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 ensure that an unexpected death of a resident on an unspecified date in July 2024 was immediately reported to the Director. The home did not report the unexpected death to the Director, of the resident, until a specified date in August 2024.

Sources: CIS, a residents clinical record, interview with a PSW, RPN, unit manager and other staff.

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