Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 5, 2012	2012_029134_0018	O-001632-12	Complaint

Licensee/Titulaire de permis

MARIANHILL INC.
600 Cecelia Street, PEMBROKE, ON, K8A-7Z3

Long-Term Care Home/Foyer de soins de longue durée

MARIANHILL
600 CECELIA STREET, PEMBROKE, ON, K8A-7Z3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

COLETTE ASSELIN (134)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 21 and 22, 2012

During the course of this inspection the Inspector conducted one complaint inspection, log # O-001632-12.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Nurse Manager, several Personal Support Workers (PSW) and several residents.

During the course of the inspection, the inspector(s) made walking rounds and reviewed the following; the official "1B PSW Night Shift Routine", several residents' Health Records, the Night Shift Routine worksheets used by staff, the list of eleven (11) residents to be dressed and transferred out of bed by night staff, the list of residents to be transferred out of bed only if awake, the bath list for five (5) residents who are to be bathed prior to breakfast.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The Licensee has failed to comply with the O.Reg 79/10 section 41 in that, the following residents' desired bedtime and rest routines are not supported and individualized to promote comfort, rest and sleep.

On November 22, 2012 the inspector arrived at Marianhill at 5:45h. The two PSWs working the night shift on 1B were interviewed related to their morning routine and if residents were being awakened prior to 6:00. They indicated that the night shift assignment sheet specifies which residents are to be washed, dressed and transferred out of bed on the night shift. They identified five (5) residents, who are to be awakened, dressed and transferred out of bed by the night staff prior to 5:30. The night shift starts at 23:00 and ends at 7:00.

The two PSWs reported that eight residents' rooms have poor night lighting that requires them to turn on the ceiling light when they provide personal care at night. The rounds are at 2:00 AM indicating that more than 10 residents' sleep would potentially be disturbed when the bright ceiling lights are turned on.

The DOC and Nurse Manager were interviewed as it relates to their expectations of the night shift routine on 1B. Both indicated they were unaware that staff members were waking residents and were not aware that a different routine was being used by night staff. The official "1B PSW Night Shift Routine" was reviewed. There is a direction to assist residents to get up between 5:45 and 7:00 and to provide a bath or shower to those residents who are care planned to have one prior to breakfast. On November 22, 2012 the inspector observed residents # 4, # 5, # 6, # 7 and # 8, who were up in their wheelchairs and had been washed, dressed and watching TV prior to 5:45. [s. 41.]

2. The night assignment sheet, being used by staff, was reviewed and resident # 6 is on the the list to be dressed and transferred out of bed by the night staff. [s. 41.]

3. Resident # 6 was observed sitting in a wheelchair and watching TV in the lounge. The resident was dressed and had been transferred out of bed prior to 5:45. The resident was interviewed and reported that getting up this early was not a choice. The resident indicated that the preference would be to sleep in; that getting up so early makes for a long day. The resident further indicated that the night staff will say the following: " We have to get the work done, so we can carry on the load".

Resident # 6's plan of care was reviewed. There is an entry specifying the following regarding the resident's preference related to rest and sleep: "Prefers to get up at 0700 hrs and to go to bed at 2000 hrs. Requires rest periods throughout the day after meals". [s. 41.]

4. Resident # 5 has cognitive deficit and was up prior to 5:45 on November 22, 2012. The resident was observed sleeping in a lazy boy chair with the ceiling lights on and the TV on. The resident's plan of care was reviewed. There are no clear directions to staff regarding this resident's preference related to rest and sleep. As such, rest and sleep were not promoted for this resident. [s. 41.]

5. Resident # 8 with cognitive deficit was up prior to 5:45 on November 22, 2012. This resident was observed sleeping in a tilt chair with the ceiling lights on and the TV on. The plan of care was reviewed. The directions provided for staff regarding this resident's sleep and rest preference are as followed: "Prefers to get up at 0700 hrs and prefers to go to bed at 2100 hrs". [s. 41.]

6. Resident # 7 with cognitive deficit was up prior to 5:45 on November 22, 2012. The resident was observed to be dressed, sleeping in a wheelchair in the TV lounge, while two other residents were watching TV. The resident's plan of care was reviewed. There is an indication that the resident's preference regarding rest and sleep is as follows: "Prefers to get up at 0700 and prefers to go to bed at 1900. Requires a rest in the afternoon after lunch". As such resident # 7's desired bedtime and rest routine is not supported and individualized to promote comfort rest and sleep. [s. 41.]

7. Resident # 4 was observed at 6:00 to be dressed and sitting in a wheelchair watching TV in the lounge with 2 other residents. The resident had been transferred out of bed prior to 5:45.

The resident's plan of care was reviewed and there is an unclear direction to staff regarding this resident's sleep and rest pattern. The entry is as follows: "Prefers to get up b/w "0760-0700 hrs", prefers to go to bed at around 2100 hrs, provide specific HS routine. Has a smart alarm as resident tends to get up during the night without assistance". [s. 41.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that the night staff is aware of the updated "1B PSW's Night Shift Routine", that residents' individualized desired rest routines are supported and communicated clearly in the residents' plan of care; that the night lights are repaired to ensure residents' sleep is not disrupted by bright lights, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The Licensee failed to comply with section 6 (1) c of the LTCHA 2007, in that the plan of care does not set out clear directions to staff as it relates to resident # 5's preferences for sleep and rest.

On November 22, 2012 the inspector arrived on unit 1B at 5:45h. The two PSWs working the night shift were interviewed related to their morning routine and if residents were awakened prior to 6:00. They indicated that their night shift assignment provides the list of residents who are to be dressed and transferred out of bed by night staff. Resident #5 was on the list of those residents to be awakened and transferred out of bed by night staff.

Resident #5 suffers from cognitive deficit. This resident was awakened washed, dressed and positioned in a lazy boy chair prior to 5:30 on November 22, 2012. The inspector observed the resident sleeping in the lazy boy chair with the ceiling lights and the TV turned on. The resident's plan of care was reviewed. There are no clear directions to staff regarding the resident's preference related to sleep and rest. [s. 6. (1) (c)]

Issued on this 5th day of December, 2012

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Colette Asselin, LTCH Inspectn #134