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

Division de la responsabilisation et de la performance du système de santé
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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
Aug 21, 2013	2013_230134_0012	O-000357-13, O-000708-13	Critical Incident System

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

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 15 and 16, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Unit Manager, several Registered Practical Nurses, the Nurse Practitioner, several Personal Support Workers and with several residents.

During the course of the inspection, the inspector(s) reviewed several residents' health records, toured the locked unit and observed the dining experience on the locked unit.

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

Responsive Behaviours

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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to comply with the LTCHA, 2007 S.O 2007, c.8, section 24 (1) (2) in that it did not immediately report to the Director an incident of resident to resident abuse, which resulted in harm to a resident.

On a specified day in July, 2013, Resident #2, who has responsive behaviours, hit and knocked down co-resident #4. Resident #2 was trying to exit the unit to go outside to the outdoor garden and Resident #4 did not move out of the way. During the physical altercation Resident #4 sustained several minor injuries.

The incident of resident to resident physical abuse, which resulted in an injury, was reported to the Director two days after the incident of physical abuse occurred and not immediately as per legislative requirement. [s. 24. (1) 2.]

Issued on this 21st day of August, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Colette Asselin, LTCH Inspector #134