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**


**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de sions de longue durée**

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| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| May 31, 2016 | 2016_382596_0007 | 003655-14 | Complaint |

## Licensee/Titulaire de permis

MARIANN NURSING HOME AND RESIDENCE
9915 YONGE STREET RICHMOND HILL ON L4C 1V1

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

MARIANN HOME
9915 YONGE STREET RICHMOND HILL ON L4C 1V1

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

THERESA BERDOE-YOUNG (596)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): April 13, 14, 15, 18, 19, 20, 21, 22, 25, 27, and 28, 2016.**

**This inspection was inspected concurrently with RQI inspection # 2016_413500_0006.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), registered staff, personal support workers (PSW) and family member.**

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

**During the course of this inspection, Non-Compliances were issued.**
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Record review of an identified resident's MDS assessment and care plan indicated that resident required one person assistance with toileting.
Review of the resident's progress notes on a specified date in July 2014, indicated that the resident was transferred to the toilet by PSW #106. The PSW then left the resident on the toilet for a few minutes, returned and found that the resident had fallen and was sitting on the bathroom floor.

Interview with PSW #106 revealed that on the above mentioned date she assisted the identified resident to the toilet and couldn't remember why she left resident for a few minutes, possibly to answer another resident's call bell. When she returned the resident had fallen in the bathroom. PSW #106 admitted that she should not have left the resident unattended.

Interview with RN #103 and the Administrator confirmed that residents' who require assistance with toileting should not be left unattended by staff. [s. 6. (7)]

***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 to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff**

**Specifically failed to comply with the following:**

**s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:**
**1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that direct care staff were provided training in falls prevention and management.

Record review of the home's falls prevention training records for 2015 and interview with the administrator revealed that seven casual staff out of 85 were not trained. [s. 221. (1) 1.]

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**Issued on this 31st day of May, 2016**

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

**Original report signed by the inspector.**