Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 28, 2021	2021_882760_0016	021718-20, 005188-21, 005959-21, 007403-21	Critical Incident System

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

JACK SHI (760)

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): May 25, 26, 27, 28, 2021.

The following intakes were completed in this critical incident inspection:

Three logs were related to a fall;
One log was related to an injury of an unknown cause.

During the course of the inspection, the inspector(s) spoke with a Housekeeper, a Physiotherapist (PT), RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector toured the home, observed Infection Prevention and Control (IPAC) practices, observed care activities on the units, reviewed relevant policies and procedures and reviewed resident records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Pain
Personal Support Services

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

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	Légende 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Pain Management policy was complied with, for a resident.

Ontario Regulation 79/10, s. 48. (1) 4 indicates that a pain management program is developed and implemented in the home that identifies and manages pain in residents.

Specifically, staff did not comply with the home's policy and procedure titled, "Pain Management", dated October 2020. The policy states that the registered nursing staff are to complete a pain assessment with a clinically appropriate tool when a resident experiences a change in their health status.

According to the progress notes and an interview with an RN, the resident experienced a change in their health condition and had also demonstrated signs and symptoms of pain. A review of the resident's electronic chart and an interview with the DOC confirmed that pain interventions were provided to the resident, but a clinically appropriate pain assessment tool was not completed. The DOC added that based on the policy, the home's pain assessment tool should have been utilized for the resident. The DOC stated that the failure to perform a pain assessment on the resident may result in the resident's comfort levels not being addressed and whether the interventions are meeting the resident's overall health status.

Sources: A resident's progress notes, electronic chart and assessments; The home's pain management policy; Interviews with the DOC, an RN and other staff. [s. 8. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

The home's Falls Prevention and Management policy indicated after a resident sustains a fall, the risk management report will be completed electronically. A review of resident's risk management report indicated that a number of assessments were not completed after this resident fell. The RPN stated they did not complete the required assessments and should have done so based on the home's policy and post fall assessment tool. The DOC added that the risk management is the clinical tool used by the home after a resident falls and should have been completed by the RPN following this resident's fall. There was potential risk to the resident, as the failure to complete a post-fall assessment may result in unidentified injuries and missed opportunities to implement interventions following the resident's fall.

Sources: Review of a resident's progress notes; Home's Falls Prevention and Management policy; Interviews with an RPN, the DOC and other staff. [s. 49. (2)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a PSW was mentioned in the report to the Director, regarding the fall of a resident.

A CIS report was submitted by the home resident to the resident's fall. According to the progress notes and interviews with the staff, this PSW had responded to the resident's fall. The DOC confirmed that the name of the PSW was not in the report and should have been.

Sources: A CIS report; Interview with a PSW, the DOC and other staff. [s. 107. (4) 2.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a housekeeper participated in the home's infection prevention and control (IPAC) program.

An observation made during the inspection demonstrated that a housekeeper was exiting a resident’s room without doffing off any personal protective equipment (PPE). The signage on the resident's room door indicated the resident was on precautions. The housekeeper stated they forgot to wear the appropriate PPE when entering this resident's room. The DOC stated that all staff are expected to wear the appropriate PPE when they enter a resident's room on precautions.

This observation demonstrated that there was a potential risk to the resident inside that room from the housekeeper, as there could be transmission of infectious agents, if IPAC measures are not adhered.

Sources: Observations on a resident unit; interviews with a housekeeper, the DOC and other staff. [s. 229. (4)]

Issued on this 1st day of June, 2021

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

Original report signed by the inspector.