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
Feb 14, 2022	2022_958787_0001	017904-21, 000810-22	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

BRITNEY BARTLEY (732787), MOSES NEELAM (762)

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): January 25, 26, 2022

The following intake was completed in this complaint inspection
- Logs/CIS related to an incident of a resident that resulted in a significant change in health status.

During the course of the inspection, the inspector(s) spoke with Registered Nurse (RN), Personal Support Workers (PSWs), and Assistant Director of Care (ADOC).

During the course of this inspection, the inspectors reviewed records, conducted observations and toured resident home areas.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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 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 :

The licensee has failed to ensure that there is a written plan of care that sets out the planned care for resident #001.

Resident #001 suffered an incident with injury that resulted in significant change in health status. When conducting interviews, (PSWs) #100, #102 and RN #103, indicated that they were applying a specific device on the resident. A review of the resident clinical records demonstrated the specific device was not in the plan of care and was discontinued more than one year ago.

In separate interviews, PSW #100 and #102 indicated they applied the specific device on the resident. PSW #102 and RN #103, said resident was using the device two weeks leading up to the incident. ADOC #104 said staff applied the device on occasions on the resident if needed, and they did not need to add the intervention to the plan of care. ADOC #104 further added the device required an assessment from the falls team before being added to the plan of care. The ADOC #104 indicated that the resident did not require the device as the resident's last incident was more than one year ago. By not having the device in the written plan of care posed a risk of staff not knowing what interventions are in place.

Sources: Resident #001’s plan of care and most recent care plan; Interview with PSW #100, PSW #102, RN #103 and ADOC #104.

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 there is a written plan of care for each resident that sets out,

(a) the planned care for the resident, to be implemented voluntarily.

Issued on this 18th day of February, 2022

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

Original report signed by the inspector.