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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Aug 21, 2015	2015_288549_0021	O-002372-15	Resident Quality Inspection

Licensee/Titulaire de permis

COUNTY OF RENFREW
9 INTERNATIONAL DRIVE PEMBROKE ON K8A 6W5

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

MIRAMICHI LODGE
725 Pembroke Street West PEMBROKE ON K8A 8S6

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

RENA BOWEN (549), PAULA MACDONALD (138), RUZICA SUBOTIC-HOWELL (548), WENDY PATTERSON (556)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): August 10,11,12,13,14,17,18,19, 2015.

The following Logs were inspected concurrently with the Resident Quality Inspection: O-001358-14,O-001480-15,O-001503-15,O-001668-15,O-001738-15,O-001759-15,O-001829-15, O-001982-15, O-002131-15,O-002189-15,O-002349-15,O-002308-15, O-002358-15, O-002457-15 and O-002583-15

During the course of the inspection, the inspector(s) spoke with several Residents, Family Members, the Resident Council President, the Family Council President, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RNs), the home's two Resident Care Coordinators, the Food Services Supervisor, the Environmental Services Supervisor, the Administrative Assistant Finance, a Community Care Access Worker, a Physiotherapy Assistant, the Director of Care and the Administrator.
In addition the inspectors completed a walk through tour of all resident areas, observed a meal service, medication administration, resident care, staff to resident interactions, resident to resident interactions, infection prevention and control practices, reviewed several resident's health care files, the home's admission package, internal investigation documentation, several of the home's policies and procedures, Family Council and Resident Council meeting minutes

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Continence Care and Bowel Management
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **5 WN(s)**
- **2 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	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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff.

On August 10, 2015 a tour of the home was conducted by Inspector #556. During the tour the following areas were found to be accessible.
• Unit 1-A door #131 labelled storage was found to be unlocked. The room contained continence products and equipment such as wheel chair parts and walkers.
• Unit 1-A door #123 was locked but the lock had not engaged and the door was easily pushed open. The room had electrical panels on the interior walls.
• Unit 1-B door #121 had a sign on the door that said "O2 door must be locked", the door was locked but the lock had not engaged and the door was easily pushed open.
• Unit 2-A door #223 was locked but the lock had not engaged and the door was easily pushed open. The room had electrical panels on the interior walls.
• Unit 2-B door #213, labelled storage, was found to be unlocked. The room contained seasonal decorations, and equipment.
• Unit 3-A door #323 was locked but the lock had not engaged and the door was easily pushed open. The room had electrical panels on the interior walls.
• Unit 3-A door #327 labelled soiled utility room was locked but the lock had not engaged and the door was easily pushed open.
• Unit 3-B doors #313 & #331 labelled storage were not locked and contained equipment and continence products.
• Unit 3-B door #325 was locked but the lock had not engaged and the door was easily pushed open and contained chemicals.

All of the above mentioned doors were equipped with locks, did not have call bells inside the room, and were not being supervised by staff.

On August 17, 2015 RCC #105 toured the home with Inspector #556 and indicated that all of the above mentioned doors leading to non-residential areas and are to be kept closed and locked. [s. 9. (1) 2.]

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 all doors leading to non-residential areas are kept locked when not being supervised by staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The home failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment

Upon record review,progress note entries indicated that on a specific date in March 2015 Resident #039 presented with “2 pea size open areas and 3.5 cm black eschar ” with serous fluid and dressing 100 % soaked. On a specific date in March 2015 the size of the open area is described as “4cm” with serous drainage and dressing 100 % soaked" and, on a specific date in April 2015 the wound circumference is described as "5 x 3.5 cm in diameter with increased eschar and draining scant serous fluid". On a specific date in April 2015 the resident presented with “ a new Stage 1 area 10x10 with center black/blue bruised".

Inspector #548 was unable to locate any skin and wound assessments in the health record. On August 13, 2015 during an interview RN#109 and RN#117, both involved in the care of altered skin integrity for residents, confirmed there is no clinical tool specifically designed for skin and wound assessment used at the home.

The home‘s policy, provided to inspector by RCC# 105, titled: Skin Care and Wounds-Pressure Ulcers, SOP#: N-1010, dated March 2006 indicated that residents exhibiting a sign of skin breakdown receive a skin assessment. The policy reads: the assessment will include the Wound Assessment Tool. The tool titled: Wound/Pressure Ulcer Progress Form is specifically designed for skin and wound assessments, as confirmed by RCC#105.

On August 14, 2015 during an interview RCC# 105 indicated that the tool Wound/Pressure Ulcer Progress Form is no longer in use at the home and was not replaced with another clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #3: 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 failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Resident #038 requires assistance with personal care. On August 11, 2015 the resident was observed by Inspector #548 to have dark matter under his/her fingernails.

The resident plan of care indicates that the resident is to have nail care completed on bath days.

The resident is scheduled for a day bath on a specific date in August 2015. The PSW #112 reported that the resident does not present with any behaviours during care and is accepting of personal care and grooming. PSW #112 indicated that nail care is provided during bath days.

Flow sheets for August 2015 were reviewed and indicated that the resident received his/her bath and that nail care was provided.

The resident was subsequently observed on his/her bath day by Inspector #548 to have dark matter under his/her fingernails.

As such, the licensee failed to ensure that Resident's #038 nail care was provided as specified in the plan of care. [s. 6. (7)]

2. During the course of an inspection a Critical Incident Report (CIR) was reviewed and indicated that on a specific date in February 2015 Resident #020, who was sitting in a wheelchair, had not been toileted or repositioned between specific hours.

Inspector #556 reviewed the homes internal investigation report regarding the incident which indicated that the internal investigation was completed on a specific date in March 2015 and concluded that Resident #020 had not been repositioned, or toileted during the above mentioned hours on a specific date in February 2015.

A review of Resident #020's plan of care indicated that the resident was to be reposition every 2 hours when in bed or up in wheelchair to prevent breakdown, and further indicated that the resident was to be routinely toileted every 2 hours.

In an interview RCC #105 stated that during the evening shift on a specific date in February 2015 there was always at least 2 staff members on the unit where Resident #020 resided and therefore nothing should have prevented the toileting or repositioning of the resident. [Log O-001759-15] [s. 6. (7)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to respond to the Residents' Council (RC) in writing within 10 days of receiving concerns or recommendations about the operation of the home.

A review was conducted of the RC meeting minutes for the past year. In the meeting minutes of July 2014 a concern was documented related to the home running short of one of the dessert choices; and in the meeting minutes of April 2015 a recommendation was made to have more bingos and classical music. In the most recent RC meeting minutes dated August 7, 2015 concerns were documented related to staff not always wearing name tags, too many cancelled activities, and food not always being hot enough.

In an interview staff member #116, who is the liaison between the home and the Residents' Council, stated that the process followed by the home is that when a concern or recommendation is raised at a RC meeting staff member #116 emails the manager who is directly responsible for the issue. The manager then emails their response back to staff member #116 who puts it in the RC binder to be shared at the next RC meeting. [s. 57. (2)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)
(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 78 (2)

(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained; 2007, c. 8, s. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges; 2007, c. 8, s. 78 (2)
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs; 2007, c. 8, s. 78 (2)
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents; 2007, c. 8, s. 78 (2)
(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package; 2007, c. 8, s. 78 (2)
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations; 2007, c. 8, s. 78 (2)
(q) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2)
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. The license failed to comply with section 78.(2)(c) in that the licensee failed to include the long term care home's policy to promote zero tolerance of abuse and neglect of residents in the package of information that, according to section 78.(1), is to be provided to every resident and to the substitute decision maker of the resident, if any, at the time that the resident is admitted.

Inspector #138 reviewed Critical Incident Report submitted by the home to the Director outlining an incident of abuse to Resident #047 by the resident's substitute decision maker (SDM). The inspector reviewed the licensee's responsibility to communicate the home's policy to promote zero tolerance of abuse and neglect of residents to the SDM according to section 20.(3) of the Act. One way in which the home communicates this policy is through the package of information given to the SDM, according to this section of the Act, on the resident's admission. It was noted by the inspector when reviewing the home's package of information for residents and SDMs, as provided by the Nursing Assistant #120, that the home's policy to promote zero tolerance of abuse and neglect of residents was not included in the package of information. The policy that outlines admissions, also provided by Nursing Assistant #120, demonstrated the specific documents to be reviewed with residents and SDMs at the resident admission. This policy on admission did not include reviewing the home's policy to promote zero tolerance of abuse and neglect of residents.

On August 18, 2015, the inspector spoke with the Administrative Assistant Finance who confirmed to the inspector that she is responsible to give and review the package of information to the residents and SDMs on the admission of a resident. She confirmed that the package of information contains the Resident Handbook that makes reference to the home's policy to promote zero tolerance of abuse and neglect of residents but stated that the home's full policy to promote zero tolerance of abuse to residents is not part of the package of information and is not provided to residents or SDMs upon a resident's admission.
(O-002308-15) [s. 78. (2) (c)]

Issued on this 21st day of August, 2015

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

Original report signed by the inspector.