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 prévue 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 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
Jan 14, 2019	2018_770178_0025	006997-17, 014464-17, 017508-17, 020650-17, 023297-17, 027090-17, 027096-17, 029608-17, 029688-17	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the 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

SUSAN LUI (178)

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): December 11, 12, 13, 14, 18, 19, 20, 31, 2018, January 4, 8, 9, 10, 11, 2019.

The following Critical Incident Logs were inspected:
-014464-17 (CIR #M621-000018-17), 029608-17 (CIR #M621-000029-17), and 029688-17 (CIR #M621-000030-17), all related to resident falls with injury
-027090-17 (CIR #M621-000026-17) related to alleged neglect of a resident
-023297-17 (CIR #M621-000025-17) and 027096-17 (CIR #M621-000027-17) related to alleged staff to resident abuse
-017508-17 (CIR #M621-000021-17) related to alleged resident to resident physical abuse
-006997-17 (CIR #M621-000012-17) related to a controlled substance missing \unaccounted
-020650-17 (CIR #M621-000023-17), related to a complaint letter received by the home from the family of a resident

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers, Registered Nurses (RNs), Registered Practical Nurses (RPNs), the Resident Care Coordinator (RCC), and the Director of Care (DOC).

During the course of the inspection, the inspector also observed residents and their interactions with staff and visitors, reviewed residents' health records, including progress notes, assessment records and plans of care, reviewed home records, including training records, Risk Management Reports and Employer Investigation Reports into abuse allegations.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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. 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 has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred, did immediately report the suspicion and the information upon which it was based to the Director under the Long Term Care Homes Act (LTCHA).

This non compliance is related to Log #027096-17, CIR #M621-000027-17.

Critical Incident Report (CIR) #M621-000027-17 was submitted by the licensee to the Director under the LTCHA on an identified date, indicating that on the previous evening, RN #106 received a report that PSW #104 had witnessed PSW #108 providing care in a rough manner to resident #003 and resident #004. The critical incident report indicated that the allegation was reported to Resident Care Coordinator (RCC) #110 on the morning after the alleged rough care was reported to RN #106. The CIR further indicated that the MOHLTC after hours pager was not contacted about the incident.

During an interview with Inspector #178 on December 14, 2018, PSW #104 indicated that they witnessed PSW #108 providing care in an inappropriate and rough manner to resident #003 and resident #004 on a shift during an identified time period.

During an interview with Inspector #178 on December 19, 2018, RN #106 indicated that late in the evening on an identified date, PSW #104 reported that they had witnessed PSW #108 providing rough care to resident #003 and resident #004. RN #106 indicated that after receiving the report, they assessed the residents and the residents were unharmed. RN #106 indicated that they considered the report to be an allegation of resident abuse, and they informed Resident Care Coordinator #110 by sending an email or leaving a written letter for RCC #110, and then followed up with RCC #110 the following day to ensure the report was received. RN #104 indicated that they would normally call to inform the Manager on Call (MOC) of an abuse allegation right away, and then the MOC would immediately inform the MOHLTC of the alleged abuse, using the after hours phone line. RN #104 could not remember if they called the MOC about the incident of alleged rough care.

Review of the home's Employer Investigation Report of this incident indicated that RCC #110 received an email from RN #106 on an identified date, expressing concerns regarding resident care provided by PSW #108 the previous evening. The Investigation Report indicated that RCC #110 met with RN #106 on the day that RCC #110 received the email, and expressed to RN #106 that the incident is considered alleged abuse and asked why the Manager on Call was not called. The Investigation Report indicated that RN #106 expressed to RCC #110 that the Director of Care had been present in the home the previous evening, and RN #106 went to see the DOC, but missed them. The Investigation Report indicated that RN #106 agreed that they should have called the MOC the previous evening to report the alleged abuse.

During an interview with Inspector #178 on January 4, 2019, the DOC indicated that after being informed of the allegation of staff to resident abuse on an identified date, RN #106 attempted to report the allegation to the DOC, but the DOC was unavailable. The DOC indicated that RN#106 should have then contacted the Manager on Call to immediately report the allegation, but did not. RN #106 instead sent an email RCC #110, which was received the next morning. As a result, the allegation was not immediately reported to the Director under the LTCHA as required. [s. 24. (1)]

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 person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, does immediately report the suspicion and the information upon which it was based to the Director under the Long Term Care Homes Act (LTCHA), to be implemented voluntarily.

Issued on this 15th day of January, 2019

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

Original report signed by the inspector.