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 1, 2021	2021_785732_0002	004660-20, 005512-20, 012860-20, 014490-20, 017530-20, 024278-20	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

EMILY PRIOR (732)

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): January 18 - 22, and 25 - 27, 2021.

The following logs were inspected in this Critical Incident System inspection:

Log #024278-20 (CIR #M621-000038-20) related to falls prevention and management;

Log #017530-20 (CIR #M621-000028-20) and log #014490-20 (CIR #M621-000022-20) related to responsive behaviours;

Log #012860-20 (CIR #M621-000020-20) related to injury with transfer to hospital and change in condition; and

Log #005512-20 (CIR #M621-000011-20) and Log #004660-20 (CIR #M621-000009-20) related to alleged improper/incompetent treatment of a resident

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Resident Care Coordinators (RCC), a Registered Nurse, Registered Practical Nurses, Personal Support Workers (PSW), and housekeepers.

In addition, the inspector(s) reviewed Critical Incident Reports (CIR), resident health care records, and relevant policies and procedures. The inspector(s) observed the provision of care and services to residents, resident care areas, resident to resident interactions, and infection prevention and control measures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **1 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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that a PSW used safe techniques while transferring a resident into and out of the tub using a mechanical lift.

In March 2020, a PSW transferred a resident into the tub and out of the tub using a mechanical lift without the assistance of another staff member. The resident's plan of care indicated that they required two staff with mechanical lift for all transfers. Furthermore, the licensee's 'Standard Operating Procedures: Mechanical Lifts (ARJO)' described that two staff members are required to assist in the complete transfer of any resident when using a mechanical lift.

As a result of these actions, the PSW put the resident at risk of injury.

Sources: Standard Operating Procedures: Mechanical Lifts (ARJO); resident's health care record; Critical Incident Report; and interviews with the resident and RCC. [s. 36.]

Issued on this 2nd day of February, 2021

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

Original report signed by the inspector.