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

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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 17, 2021	2021_785732_0013	001353-21, 003508-21, 007205-21	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): May 10 to May 13, 2021.

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

Log #003508-21 (CI #M621-000008-21) related to an unexpected death;
Log #001353-21 (CI #M621-000004-21) related to falls prevention and management; and
Log #007205-21 (CI #M621-000012-21 related to alleged improper care of a resident

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

The inspector(s) also observed the provision of care and services to residents, staff to resident interactions, dining service, and infection prevention and control practices; as well as reviewed resident health care records and relevant policies and procedures.

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

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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the hand hygiene program was in place in accordance with evidence-based practices, specifically related to assisting residents to perform hand hygiene before and after meals.

Evidenced based practice indicates that staff should assist residents to perform hand hygiene before and after meals. A lunch meal service observation on a unit revealed that residents' hands were not cleaned before the meal.

The DOC explained that priority hand hygiene for residents is before and after meals, however the licensee's Hand Hygiene Standard Operating Procedure did not indicate this.

Lack of hand hygiene increases the risk of disease transmission among residents and staff.

Sources: Public Health Ontario - Best Practices for Hand Hygiene in All Health Care Settings, 4th Edition, Miramichi Lodge Standard Operating Procedures, Hand Hygiene; observation of lunch service, and interview with DOC. [s. 229. (9)]

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 hand hygiene program is in place in accordance with evidence-based practices, to be implemented voluntarily.

Issued on this 20th day of May, 2021

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

Original report signed by the inspector.