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
Oct 19, 2021	2021_730593_0002	010871-21, 014524-21	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

GILLIAN CHAMBERLIN (593)

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): October 1, 4, 7, 8, 12, 13, 2021.

Two critical incidents were inspected. Log #014524-21 (M621-000016-21) related to hospitalization and change in condition; and log #010871-21 (M621-000013-21) related to alleged improper/incompetent treatment of a resident.

During the course of the inspection, the inspector(s) spoke with the Acting Director of Care (ADOC), Registered Nursing staff, Housekeeping staff, Personal Support Workers (PSW) and residents.

The inspector observed the provision of care and services to residents, infection, prevention and control practices; staff to resident interactions, resident to resident interactions, residents' environment, and reviewed resident health care records and licensee policies.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 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	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. (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 has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

The residents plan of care identified that the resident required treatments on bath days (twice per week) and PRN (as needed). There was also a daily treatment required.

The treatment administration record identified that there was no treatment completed on one date which was a scheduled bath day. The next treatment completed was four days later. The TAR also identified that there was no treatment completed for the other area on nine days in a month period. Progress notes were reviewed and there was no documentation to support that these treatments did occur.

As per interviews with Acting DOC and a RPN, treatments for skin and wound are documented in the TAR binder and usually supported with a progress note.

Sources: Acting DOC and RPN interviews, resident health care record and critical incident report M621-000016-21. [s. 6. (7)] [s. 6. (7)]

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 ensuring that the care set out in the plan of care is provided to a resident as specified in the plan, to be implemented voluntarily.

WN #2: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

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.

Meal service observations in one resident home area revealed that resident hands were not cleaned before or after the meal service. Specifically three residents were observed to enter and leave the dining room without hand washing before and after their meal.

Acting DOC indicated that it was the responsibility of the PSWs to ensure that residents hands were washed before and after meals.

Evidenced-based practice indicates that staff should assist residents to perform hand hygiene before and after meals. Hand hygiene helps prevent disease transmission among residents and staff.

Sources: Public Health Ontario- Best Practices for Hand Hygiene in all Health Care Settings, 4th edition (April 2014), observation of meal service, interview with Acting DOC and other staff [s. 229. (9)] [s. 229. (4)]

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 ensuring that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee policy Skin and Wound Program, was complied with.

A policy under the skin and wound program, indicated that The Pressure Ulcer Scale for Healing (PUSH Tool) is used for skin and wound assessment at the home, and has been validated for all wound types. Wounds will be assessed at a minimum of weekly thereafter until healed and the RN/RPN will note assessment findings, progress towards healing according to the PUSH Tool.

A residents plan of care identified that the resident required weekly skin and wound assessment using the PUSH tool and that this was to be completed Sunday evening.

The treatment administration record (TAR) identified that there was no PUSH tool completed for two dates in August, 2021. Progress notes were reviewed and there was no documentation to support that these assessments using the PUSH tool did occur.

As per an interview with Acting DOC, the PUSH tool is to be completed weekly for all residents with altered skin integrity.

Sources: Acting DOC interview, resident health care record, critical incident report and licensee policy Skin and Wound Program. [s. 8. (1) b] [s. 8. (1)]

Issued on this 20th day of October, 2021

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

Original report signed by the inspector.