Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
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Original Public Report

Report Issue Date: March 3, 2023

Inspection Number: 2023-1616-0002

Inspection Type:
Complaint
Critical Incident System

Licensee: The Corporation of the County of Renfrew

Long Term Care Home and City: Miramichi Lodge, Pembroke

Lead Inspector	**Inspector Digital Signature**
Karen Buness (720483)	Karen Lynne Buness Digitally signed by Karen Lynne Buness Date: 2023.03.08 14:05:33 -05'00'

Additional Inspector(s)
Susan Lui (178)
Anandraj Natarajan (573)
Lisa Cummings (756)
Polly Gray-Pattemore (740790)
Emily Prior (732)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):

January 4, 6, 9, 10, 11, 12, 23, 24, 25, 26, 27, 30, 31, February 2, 3, 6, 2023

The following intake(s) were inspected:

- Intake: #00001051-Resident transfer to hospital.
- Intake: #00002204-Staff to resident alleged sexual abuse.
- Intake: #00003613-Resident to resident physical abuse
- Intake: #00004169-Fall of resident resulting in a significant change in condition
- Intake: #00006193-Fall of resident resulting in a significant change in condition
- Intake: #00007376-Fall of resident resulting in a significant change in condition
- Intake: #00007751-Staff to resident alleged emotional abuse
- Intake: #00011865-Fall of resident resulting in significant change in condition
- Intake: #00011915-Fall of resident resulting in significant change in condition

- Intake: #00012121-Resident to resident physical, emotional and verbal abuse.
- Intake: #00013929-Unexpected Death of a resident
- Intake: #00014811-Complaint regarding resident care and nursing and personal support services.
- Intake: #00015022- Complaint related to resident care, nutritional care and hydration programs
- Intake: #00016105- Complaint regarding care and services
- Intake: #00016857, #00017284 and #00017329 -Complaint regarding care and provision of nutrition
- Intake: #00016860-Staff to resident alleged physical and emotional abuse.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

FLTCA, 2021, s. 19 (2)

Non-compliance was found during this inspection and was remedied by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

The licensee has failed to ensure that the home is maintained in a good state of repair.

The Inspector observed the dining room ceiling on a resident unit. There was a water stain with the ceiling paint that had peeled away and cracked. The Inspector reported the ceiling observations to the management of the home and this was repaired during this inspection.

[573]

Date Remedy Implemented: January 27, 2023

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (2)

The licensee has failed to ensure that the results of the abuse investigation were reported to the Director.

Rationale and Summary: A Critical Incident Report (CIR) was submitted to the Ministry of Long-Term Care (MLTC) related to alleged staff to resident sexual abuse. During the inspection it was reported that the leadership team in the home had initiated an investigation and completed their investigation with no staff to resident abuse substantiated. The review of the CIR indicated that an amendment was not completed by the licensee after the initial report. During an interview, the DOC confirmed that there were no amendments made to the CIR after the initial report to indicate the outcome/ results of the licensee's internal investigation.

Sources: Critical Incident Report, the home’s internal investigation documentation and interview with the DOC.

[573]

WRITTEN NOTIFICATION: Doors in a home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 12 (1) 1. i.

The licensee has failed to ensure that the doors leading to the stairways were closed and locked following a power outage on June 3, 2022.

In accordance with O. Reg. s. 12. (1) 1. i., the licensee shall ensure that all doors leading to stairways are kept closed and locked.

On a specific date there was a power outage that required the locks for the stairwell doors to be reset. Staff stated they found a resident in the stairwell, at the bottom of the stairs. The resident explained at that time that they were trying to leave and fell down the stairs. The resident was transferred to hospital and returned to the home the same day without injury.

A staff member stated that once they were notified the door to the stairwell was unlocked, they checked all stairwell doors and found multiple stairwell doors in a resident home areas to be unlocked due to a system failure.

The failure to ensure all stairwell doors were locked following the power outage increased the risk of injury due to falls for residents in the B resident home areas.

Sources: Critical Incident Report, progress notes, interviews with staff.

[756]

WRITTEN NOTIFICATION: General Requirements

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 34 (1) 3.

Review of the licensee's Falls Risk Reduction Program Interprofessional Clinical Practice Guideline and Head Injury Routine Standard Operation Procedure indicated that the licensee did not ensure that the

interdisciplinary program of falls prevention and management program to reduce the incidence of falls and the risk of injury was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Rationale and Summary:
DOC acknowledged both Falls Risk Reduction Program and Head Injury Routine are part of the falls prevention and management program and was last reviewed in May 2019.

There was risk to the residents related to the licensee failure to evaluate and update at least annually the falls prevention and management program, in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Source: Miramichi Lodge Interprofessional Clinical Practice Guideline, Falls Risk Reduction Program ICPG-006, date July 2012, rev. date May 2019; Miramichi Lodge Standard Operating Procedure, Head Injury Routine SOP #:N-100, original date Sept/95, date last reviewed Dec 18/20; and interview with DOC
[740790]

WRITTEN NOTIFICATION: Required Programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 53 (1) 1.

The licensee has failed to ensure that the falls prevention and management program regarding head injury assessments and progress notes was complied with.

In accordance with O. Reg. s. 53 (1) 1., the licensee shall ensure that a falls prevention and management program is developed and implemented in the home. Further, in accordance with O. Reg. s. 11 (1) (b) the licensee shall ensure that any program required under the Regulation is complied with.

The licensee's policy, Head Injury Routine, last reviewed December, 2020, states that the neurological assessment be recorded on the Neurological Observation Sheet and to document an overall summary of the resident's condition at the end of each shift in the multi-disciplinary notes.

The Director of Care (DOC) confirmed the Head Injury Routine policy is a part of the falls prevention and management program in the home. They further clarified that the neurological assessment is

documented on the Head Injury Assessment form and the parameters for the frequency of assessment on that form should be followed. In addition, the DOC stated the summary of the resident's condition should be documented each shift in the progress notes and this should be completed for 24 hours.

A resident experienced an unwitnessed fall. Registered staff completed a post-fall assessment and documented the summary in the progress notes. No further progress notes of a summary of the resident's condition were completed on subsequent shifts. The Head Injury Assessment form was also initiated but all assessments were not completed as per the parameters listed on the form.

The failure to comply with the Head Injury Routine policy caused an increased risk of injury due to follow-up assessments not completed and documented.

Sources: Head Injury Routine, SOP # N-100, reviewed December 2020; progress notes; Head Injury Assessment form; interviews with staff

[756]