Ontario

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

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

Ottawa District
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Original Public Report

Report Issue Date: October 19, 2023	
Inspection Number: 2023-1616-0004	
Inspection Type: Complaint Critical Incident	
Licensee: The Corporation of the County of Renfrew	
Long Term Care Home and City: Miramichi Lodge, Pembroke	
Lead Inspector Gurpreet Gill (705004)	**Inspector Digital Signature**
Additional Inspector(s) Lisa Kluke (000725)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 15, 18, 19, 20, 21, 22, 25, 26, 2023

The following intake(s) were inspected:

- Intake: #00091965 and #00096510 - complaint related to care and services for a resident
- Intake: #00093524 CI: M621-000026-23 - related to a fall incident that caused injury to a resident and a significant change in condition
- Intake: #00087358 CI: M621-000014-23 - related to an alleged staff to resident abuse

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

Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident had occurred shall immediately report the suspicion and the information upon which it is based to the Director.

Rationale and Summary

A Critical Incident System (CIS) report was submitted on a day in May 2023 at 1640 hours to the Director related to an allegation of staff to resident physical abuse that occurred on the previous day at 1900 hours.

The Resident Care Coordinator indicated that the alleged incident of physical abuse was not immediately reported to the Director as an RPN failed to report the incident until the next day.

Sources: Critical Incident System report and interview with the Resident Care Coordinator. [705004]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control, specifically related to additional precautions signage indicating that enhanced IPAC control measures are in place as is required by Additional Requirement 9.1 under the IPAC Standard.

Rationale and Summary

On a day in September 2023, the inspector observed that a resident had personal protective equipment (PPE) supplies at the room entrance but there was no signage posted at the entrance to the resident's room or bed space indicating that enhanced IPAC measures were in place for this resident.

On a day in September 2023, the inspector observed that a PSW exited the resident's room, who required contact precautions. The PSW was wearing gloves but no gown when they exited the room and carried soiled laundry.

During interviews, a PSW and an RPN indicated that the resident was on contact precautions and the signage may have been misplaced. Furthermore, the RPN indicated that the PSW should wear a gown when they were providing direct care to the resident.

Staff not being aware of additional precautions and the PPE required, as signage for additional precautions was not posted for this resident, increased infection control risks among residents and staff.

Sources: Observations made by the inspector and Interviews with identified staff members. [705004]

WRITTEN NOTIFICATION: Safe storage of drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

The licensee has failed to ensure that drugs that were stored in the nursing office on a specified resident unit was secure and locked.

Rationale and Summary

On a day in September 2023, Inspector #000725 observed a container that had prescribed ointments and creams for residents in the nursing office on the specified resident unit. The nursing office was equipped with two doors to resident areas that were left open.

On the same day in September 2023 at 1732 hours, a resident was inside the nursing office alone, and then returned again at 1747 hours alone, and a PSW redirected the resident out of this space and closed both doors to this office area.

On another day in September 2023, Inspector #000725 observed the doors leading to the nursing office

where the container with prescribed ointments and creams was located to be open. An RPN indicated to Inspector #000725 that the doors to the nursing office are supposed to be kept closed and locked when no staff inside this room to prevent residents from entering this area.

As such, failing to ensure the doors to the specified resident unit's nursing office were kept closed and locked, posed a potential risk to resident access to these medications inside this area.

Sources: Observations made by the inspector and Interviews with identified staff members. [000725]