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
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Amended Public Report Cover Sheet (A2)

Amended Report Issue Date: June 3, 2024	
Original Report Issue Date: April 11, 2024	
Inspection Number: 2024-1616-0001 (A2)	
Inspection Type: Complaint Critical Incident Follow up	
Licensee: The Corporation of the County of Renfrew	
Long Term Care Home and City: Miramichi Lodge, Pembroke	
Amended By Ashley Martin (000728)	Inspector who Amended Digital Signature

AMENDED INSPECTION SUMMARY

This report has been amended to:
The compliance due date (CDD) was amended as the CDD was incorrect in the A1 report.

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Long Term Care Home and City: Miramichi Lodge, Pembroke	
Lead Inspector Shevon Thompson (000731)	Additional Inspector(s) Margaret Beamish (000723) Ashley Martin (000728) Maryse Lapensee (000727)
Amended By Ashley Martin (000728)	Inspector who Amended Digital Signature

AMENDED INSPECTION SUMMARY

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 4, 5, 6, 7, 8, 11, 12, 13, 14, and 15, 2024

The following intake(s) were inspected:
• Intake: #00022094 - CIR #M621-000006-23 - Alleged neglect of resident by staff.
• Intake: #00101638 - CIR #M621-000043-23 - Alleged abuse of a resident by staff.
• Intake: #00102200 - CIR #M621-000046-23 - Alleged abuse of a resident by staff
• Intake: #00104251 - CIR #M621-000051-23 - Alleged neglect of a resident by staff.
• Intake: #00104615 - CIR #M621-000052-23 - An injury that caused a significant change in condition for which a resident was taken to the hospital.
• Intake: #00105490 - Follow-up on -CO #002 from inspection 2023-1616-0005 related to FLTCA, 2021 - s. 28 (1) 2. Reporting certain matters to Director. CDD February 9, 2024.
• Intake: #00105491 - Follow-up on CO #003 from inspection 2023-1616-0005 related to O. Reg. 246/22 - s. 53 (1) 1. Required programs - Fall prevention and management program. CDD February 9, 2024.
• Intake: #00105492 - Follow-up on CO #004 from inspection 2023-1616-0005 related to O. Reg. 246/22 - s. 138 (1) (a) (ii). Safe storage of drugs. CDD February 9, 2024.
• Intake: #00105493 - Follow-up on CO #001 from inspection 2023-1616-0005 related to FLTCA, 2021 - s. 25 (1). Policy to promote zero tolerance. CDD February 9, 2024.
• Intake: #00107009 - complaint regarding rejection of application letter to the LTCH.
• Intake: #00107592 - CIR #M621-000004-24 - Alleged neglect of a resident by staff.
• Intake: #00107647 - CIR #M621-000003-24 - Alleged improper/Incompetent treatment of a resident by staff.
• Intake: #00109105 - Complainant regarding incident of alleged resident to resident abuse.
• Intake: #00109121 - CIR #M621-000007-24 - Alleged abuse to a resident by another resident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #002 from Inspection #2023-1616-0005 related to FLTCA, 2021, s. 28 (1) 2. inspected by Maryse Lapensee (000727)

Order #004 from Inspection #2023-1616-0005 related to O. Reg. 246/22, s. 138 (1) (a) (ii) inspected by Shevon Thompson (000731)

Order #001 from Inspection #2023-1616-0005 related to FLTCA, 2021, s. 25 (1) inspected by Shevon Thompson (000731)

The following previously issued Compliance Order(s) were found NOT to be in compliance:

Order #003 from Inspection #2023-1616-0005 related to O. Reg. 246/22, s. 53 (1) 1. inspected by Maryse Lapensee (000727)

The following Inspection Protocols were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Specific duties re cleanliness and repair

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. Specifically the licensee has failed to ensure that a medication cart was kept in a safe condition and in a good state of repair.

Rationale and Summary:
On a date in March, 2024, inspector #000731 and inspector #000728 observed a medication cart that was locked with the attached computer screen also locked. However, a drawer of the medication cart was missing which allowed for access into the medication cart and for the drawer underneath, the third drawer from the bottom, to be pulled out. The third drawer from the bottom of the cart was unlocked allowing the inspectors access to medications in bottles, plastic containers, blister

packages and the narcotic binder to be accessible.

In an interview with staff, they confirmed that the missing drawer for the medication cart was an ongoing issue and verified that there had been problems with the cart since the previous summer.

In an interview with another staff member, they confirmed that the medication cart was missing a drawer and had been missing the drawer for over two years. They affirmed that even when the cart was locked, one drawer remained open and one drawer was missing. The staff affirmed that they were expecting to get a new cart but were not aware of a specific delivery date.

During an interview with the Resident Care Coordinator (RCC), they confirmed that they were aware that the medication cart was missing a drawer and they were in the process of getting a new medication cart.

In an interview conducted with the Director of Care (DOC), they verified that they were not aware that the medication cart was missing a drawer until that day and that the cart had been replaced immediately.

Inspectors #000731 and #000728 observed that the medication cart had been replaced.

Sources: Observation of medication cart, interview with staff members, RCC and DOC. [000731]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to immediately report the suspicion and the information upon which it is based to the Director regarding an allegation of neglect by a staff member to a resident.

Rationale and Summary:
On a date in January, 2024, a family member of a resident reported allegations of neglect of a resident by a staff member to the Resident Care Coordinator (RCC). A review of the Critical Incident Report (CIR) showed that the allegations of neglect were reported to the Director through the submission of a CIR on a later date in January, 2024.

The Director of Care (DOC) acknowledged that the allegations of neglect were reported late to the Director.

Failing to immediately report the allegations of neglect may delay the investigation, placing residents at risk of harm.

Sources: CIR M621-000003-24, internal investigation notes, and interview with DOC.

[000723]

WRITTEN NOTIFICATION: Licensee consideration and approval

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (7) (b)
Authorization for admission to a home
s. 51 (7) The appropriate placement coordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 50 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or

The licensee has failed to comply with FLTCA 2021 s. 51 (7) b whereby the licensee refused an applicant's admission to the home based on reasons that are not permitted in the legislation.

Specifically, the licensee withheld an applicant's application for admission citing the staff of the home lacked the nursing expertise.

Rationale and Summary:
A review of the letter provided to the applicant's Substitute Decision Maker (SDM), stated that the home withheld approval of admission because the staff of the home lacked the nursing expertise necessary to meet the applicant's care requirements. The letter further states that the home's decision was based on the last documented Behavioural Assessment Tool which indicated the applicant exhibited responsive behaviours. The letter then states that the home would be unable to provide the

necessary care that would be required to protect the other residents at the home.

A review of the applicant's admission package, including the Behavioural Assessment Tool identified that the applicant had responsive behaviours. Listed triggers for these behaviours were unknown. Identified interventions for these behaviours were outlined. A specific intervention as outlined in the letter of refusal was not listed for these behaviours in the Behavioural Assessment Tool.

The application package also included the most recent assessment by Geriatric Mental Health, which identified that the applicant's behaviours had improved with medication adjustments and that the applicant was stable with sporadic use of as needed medications for managing behaviours.

In an interview, the Director of Care (DOC) confirmed that the applicant was refused admission based on their behaviours. The DOC stated they determined that the applicant would require a specific intervention after speaking with the DOC where the applicant currently resides. The DOC further stated that the home did not have the resources at the time to provide the applicant with this specific intervention. The home did not see it as a good fit for the applicant or other residents currently at the home without this intervention in place.

The DOC acknowledged that the home did have a responsive behaviours program which the staff in the home are trained on. Additionally, the DOC acknowledged that the home does access high intensity needs funding to support residents with responsive behaviours if they have been assessed as requiring specific intervention.

As such, withholding approval of the applicant's admission to the home was based on reasons that were not permitted within the legislation.

Sources: Applicant application package, applicant refusal letter, and interview with DOC. [000723]

WRITTEN NOTIFICATION: Conditions of license

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of license
s. 104 (4) Every licensee shall comply with the conditions to which the license is subject.

The licensee has failed to comply with Compliance Order (CO) #003 from inspection #2023-1616-0005 served on January 2, 2024, with compliance due date of February 9, 2024.

The required corrective actions taken for any deviation from the home's Head Injury Routine (HIR) policy were not implemented and there were no written records of the corrective actions.

Rationale and Summary
The home did not take corrective action for any deviation from the home's HIR policy following the audits of all the fall incidents that needed a HIR to ensure that the required assessments were being performed and documented as specified in the home's policy and did not provide a written record of the corrective actions.

The Director of Care (DOC) confirmed that there was no written record for the corrective action because no corrective action was taken following the audits. DOC stated that while conducting the audits, they were looking for initiation and completion of the HIR and looking if there was a high risk. They didn't look if the HIR

assessment were following the parameters from the home's policy.

The home's HIR policy indicates specifics parameters for a fall with a head injury or an unwitnessed fall. The HIR should be completed every thirty minutes times four, every hour times six, every four hours times two, and then every eight hours until seventy-two hours post head injury. The Registered Nurse may use discretion in increasing or decreasing these time allotments depending on the extent of injury and the resident's stability.

Inspector #00727 reviewed three resident's HIR identified in the home's audit and found deviation from the home's policy. A resident had a fall and on their last HIR assessment it indicated that the resident was "lethargic and stumbling" and no further HIR assessment was document afterward. A resident's HIR didn't follow the parameters following the resident's unwitnessed fall. Another resident sustained a fall however, their HIR assessment indicated that the resident was sleeping. No assessment was completed or documented for a specific time period within the HIR parameters.

A staff member confirmed that the parameters were not followed for a resident's HIR and that if the resident had increase confusion, the HIR should have been completed as per the parameter or more frequently.

Another staff member confirmed that the HIR assessment should have been continued for a resident who was being lethargic on their last assessment.

Both staff members confirmed that if a resident is sleeping, the expectation is to wake the resident to do the HIR assessment, and to follow the parameters as per the home's policy.

Sources: CO #003 from 2023-1616-0005; home's HIR policy, resident's electronic health records, interview with the DOC and staff members.
[000727]

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #004

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after

service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #001 Plan of care

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee shall:
A) Provide education to two staff on providing care to residents as specified in the residents' plan of care.

B) Conduct audits for the care provided by the two staff members. Audits are to be completed for each staff member, for a minimum period of four weeks, three times per week on a minimum of two residents with different level of care needs, to ensure that the care provided to the residents is as specified in the residents' plan of care.

C) Take corrective actions, if any deviation from the care identified in the residents' plan of care are identified during the audits required in section (B), to ensure

compliance with the applicable legislation;

D) Keep written records of everything required under step (a), (b), (c) and (d) of this compliance order, and must include; a copy of the training provided, those who attended with dates/times, as well as the name of the person who provided the training, the names of the residents that were audited, the dates and times of the audits, who completed the audits and any corrective action that was taken when deviation were identified during the audits. Written records must be kept for the requirements under step (a), (b), (c) and (d) of this compliance order, until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds
#1
The licensee has failed to ensure that the care set out in the plan of care was provided to the resident. Specifically, the licensee has failed to ensure that the specific safety device was attached to the resident and activated while the resident remained in bed to assist in preventing an injury from a fall.

On a date in January, 2024, a resident sustained a fall in their bedroom. Upon interview with a staff member and review of resident's records, they confirmed that the device was in use however, it was deactivated by a staff member prior to the fall.
Failing to ensure the care set out in the plan of care was provided to the resident while they remained in bed increased risk of injury to the resident.

Sources: Interview with a staff member and resident record review [000728

#2

The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in the plan.

In a review of a resident's plan of care, the inspector noted that the resident required extensive assistance of staff for all aspects of personal hygiene at bedtime, required total assistance for oral hygiene at bedtime and for staff to remove and soak the residents dentures at bed time.

In a review of the home's employer investigation report, the inspector noted the following information; a) that the resident had stated that a staff member had taken them to the bathroom, set them up at the sink and told them to complete their care. b) in an interview with the Resident Care Coordinator (RCC) and the Director Of Care (DOC), the staff member stated they had taken the resident to the bathroom and allowed the resident to do their own care. The staff confirmed that they had not read the resident's plan of care or updated them self on the plan of care.

In an interview with a staff member, they confirmed that they had brought the resident to the bathroom and had set the resident up to complete their own care and had left the room. The staff confirmed that the resident required total assistance of staff to complete all activities of daily living. Another staff member reviewed the resident's plan of care and confirmed that the resident required extensive assistance of staff for all aspects of personal hygiene.

Failure to ensure that the care set out in the plan of care was provided to the resident as specified in the plan placed the resident at an increased risk for harm.

Source: Resident's electronic health record, home's employer investigation report

and interview with staff members. [000731]

This order must be complied with by July 5, 2024

REVIEW / APPEAL INFORMATION

TAKE NOTICEThe Licensee has the right to request a review by the Director of this (these) Order(s) and / or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c / o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and / or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.