Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 18, 2014	2014_295556_0003	O-001213-13, O-001230	Critical Incident System

Licensee/Titulaire de permis

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

WENDY PATTERSON (556)

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): January 31, 2013 and February 3, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, two Resident Care Coordinators (RCC), one Registered Practical Nurse (RPN), one Personal Support Worker (PSW), three Residents, and one Mental Health Support Worker.

During the course of the inspection, the inspector(s) reviewed the medical records of resident's #001, #002, and #003, reviewed the homes policy entitled Prevention of Resident Abuse or Neglect, toured two resident care areas, and reviewed the homes internal investigation documentation.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents is complied with in that the home submitted a Critical Incident Report (CIS) to the MOHLTC indicating that on a specified date an alleged staff to resident abuse/neglect took place and the Critical Incident Report was

submitted five days later.

A review of the Home's Prevention of Resident Abuse or Neglect Policy #G-006, dated Oct/95 with a revision date APR 11/13 indicates that anyone who witnesses any form of abuse/inappropriate care or is aware of alleged or suspected abuse/inappropriate care is responsible for reporting it to their supervisor or designate immediately.

The CIS report stated that PSW S102 was at the nursing station using a cell phone while the call bells for two residents were ringing. The Critical Incident Report further stated that the call bells were answered by PSW S101. The Critical Incident Report was later amended by the home and stated that their internal investigation was competed and allegations of neglect were confirmed.

In an interview PSW S101 stated she/he was working on the unit on the day of the incident, and she/he answered the call bells while PSW S102 was on the phone. PSW S101 further stated that she/he immediately reported the incident to RPN S100 who was in charge of the unit at the time of the incident.

In an interview RPN S100 stated that the incident was reported to her/him by PSW S101 when she/he returned from lunch, and that she/he did not report it to anyone until two days later, at which time she/he reported the incident in writing to the Resident Care Coordinator (RCC).

The Home's Prevention of Resident Abuse or Neglect Policy #G-006, dated Oct/95 with a revision date APR 11/13 defines neglect as the failure by staff to provide the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents, and further states that the LTCH Act Section 24,(1) requires the Home to make immediate reports to the MOHLTC where there is reasonable suspicion that Abuse or Neglect occurred or may occur.

A review of the written statement submitted by S100 to the RCC indicates the written statement is date stamped and initialed as received by the RCC two days after the incident occurred, and states that PSW S102 was at the nursing station using his/her cell phone while two resident call bells were ringing for fifteen minutes.

In an interview the RCC stated that the investigation was initiated two days after the

incident was reported to her, and that on the following day the Administrator reviewed the RCC's initial investigation documentation and gave the direction to report the incident to the MOHLTC as suspected abuse/neglect. [s. 20. (1)]

Issued on this 3rd day of March, 2014

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

WENDY PATTERSON