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

Division de la responsabilisation et de la performance du système de santé
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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
Dec 3, 2013	2013_193150_0032	000724/000759/000480/000856-13	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

CAROLE BARIL (150)

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): November 18, 19, 20, 2013

During the course of the inspection 4 critical incident inspections were conducted.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Client Program Supervisor, Registered Nurse, Registered Practical Nurse, Personal Support Worker, Rehabilitation Assistant and Residents.

During the course of the inspection, the inspector(s) reviewed residents' health records, the home's Falls Risk Reduction Program #ICPG-006 dated July 2012, the home's Responsive Behaviours Assessment and Management Program of a Delirium dated July 2013, the home's Newly Admitted, or resident with New or Increasing Responsive Behaviours Policy dated March 2013, the home's internal investigation report, observed the staff to resident's interaction and the residents activities.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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. 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 comply with LTCHA, 2007 S.O. 2007, c.8, s.6.(7) in that the care set out in the plan of care was not provided to the resident as specified in the plan.

Resident #1 was treated for re-occurrence of wounds.

The Physician's prescribed dressing changes to the wound twice a day.

The home's administrator received from a staff member a concern that the treatment to the resident #1's wound area was not done as prescribed on two identified dates in July 2013.

The Treatment Administration Records documented by an identified Registered Staff that the change of dressing to the wound was done on two identified dates in July 2013.

The home's investigation determined that the dressing change to the resident #1's wound area was not done as prescribed on two identified dates in July 2013 by the identified Registered Staff. [s. 6. (7)]

Issued on this 4th day of December, 2013

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