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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 6, 2017	2016_289550_0038	013513-16	Resident Quality Inspection

Licensee/Titulaire de permis

The Corporation of the 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

JOANNE HENRIE (550), MEGAN MACPHAIL (551)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 17, 18, 19, 20, 21, 24, 25 and 26, 2016

Logs #013570-16, #029633-16 and #028037-16 are two critical incidents the home submitted related to the allegations of staff to resident abuse, log #023457-16 is a complaint regarding the care of a resident, log # 027367-16 is a critical incident the home submitted related to a missing resident, log #023970-16 is a critical incident the home submitted related to a fall of a resident and log #027607-16 is a complaint regarding staff issues.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, the Director of Care (DOC), two Resident Care Coordinators (RCC), the Dietician, the Physiotherapist, a rehab assistant, the Resident Programs Manager, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), the President of the Family Council, a member of the Resident Council, several family members and several residents.

In addition, the inspectors reviewed resident health care records, policies related to falls and resident council minutes. Inspectors observed resident care and services, staff and resident interaction, and meal services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

The licensee has failed to ensure that the resident's substitute decision-maker (SDM),

and any other persons designated by the resident or SDM were given an opportunity to participate fully in the development and implementation of the resident's plan of care. Resident #024 was admitted to the home in 2012 with multiple diagnoses.

A review of the resident's health care record indicated that on a specific date in 2016, at the start of the morning shift, the resident presented with lung issues that were relieved with an inhalation treatment as ordered at a specified time. The resident was described as bright and alert all shift after the treatment.
On a specific date in 2016, it was charted that the resident had specific lung issues upon auscultation of the lungs. The resident was described as extremely lethargic and had slept for most of the day.
On a specific date in 2016, it was charted that resident #024 had specific lung issues when auscultated and a non-productive cough.
On a specific date in 2016, the resident was having lung issues.
On a specific date in 2016, the resident was assessed by RN #104. In her assessment, the RN noted that she had been asked to assess the resident due to lower lip cyanosis which had resolved at the time of her assessment, and that the resident's anterior chest was auscultated for lung issues.
On 2 specific dates in 2016, the resident's respirations were described as sounding congested. On both of these days, the resident required inhalation treatments.
On a specific date in 2016, resident #024 was described as having a specific lung issues.
A review of the physician's orders indicated that on a specific date in 2016, a telephone order for a specific medication was obtained.

The resident's SDM stated that he/she was not notified when the resident presented with lung issues. The resident's SDM stated that he/she discovered that the resident was ill when he/she visited on a specific date in 2016, and noted that the resident had specific symptoms. The SDM stated that he/she asked for the resident to be assessed by the nurse practitioner (NP), but that he was not available until the following day. The resident's health care record indicated that he/she was assessed by the NP on a specific date in 2016 and two specific medications were ordered for a specific period of time.

The resident's SDM stated he/she was informed by RCC #106 that the resident's symptoms had started nine days prior to him/her becoming aware.
RCC #106 stated that the resident's SDM should have been notified when the resident experienced a change in condition so that he/she could have participated in the development and implementation of the resident's plan of care. [s. 6. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #024's substitute decision maker is given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with.

In accordance with s.30 and s.48 of Regulation 79/10, the licensee shall ensure that there is a fall prevention and management program whereby there is a written description of the program that includes relevant policies, procedures and protocols.

Resident #017 was admitted to the home on a specific date in 2016 and was ambulating using specific mobility devices. On a specific date in the summer of 2016 the resident fell in his/her room and sustained multiple fractures to specific body parts. The resident did not have a history of falls since his/her admission in the home. The inspector reviewed the resident's health care records and noted that there was no fall risk assessment

completed for this resident from the time he/she was admitted to the home and there was no identification of the resident's fall risk potential in the health care records.

The Inspector reviewed the home's fall prevention program, specifically the policy titled "Falls Risk Reduction Program", policy # ICPG-006, effective date July 2012. Under procedure, it was indicated:

1) Falls risk assessment:

A) Admission: The fall risk assessment tool found online through PCC will be used to identify risk potential. Each registered staff member will complete the tool for each resident upon admission. Completion of this assessment will result in residents being classified as high, moderate or low risk for falls.

During an interview, the Director of Care indicated to the inspector that a fall risk assessment had not been completed by the Registered Staff upon admission or any time after for resident #017. [s. 8. (1) (a),s. 8. (1) (b)]

2. According to the Falls Reduction Program (ICPG-006), Post Fall Follow-up Protocol, a resident experiencing more than one fall in a month period will have a "Frequent Faller Assessment" completed.

Resident #022 was admitted to the home in the spring of 2016. Resident #018 ambulated with a mobility device.

In the six (6) months since resident #022 was admitted to the home, he/she fell thirty three (33) times.

On a specific date and time in 2016, the resident fell and required to be transferred to the hospital. The resident was diagnosed with a specific medical condition.

A review of the resident's health care record indicated that a Frequent Fallers Assessment was completed on a specific date in 2016 after the resident experienced two (2) falls. A Frequent Fallers Assessment was not completed at any other time when the resident experienced more than one fall in a month period.
[s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that fall risk assessments are completed upon a resident's admission and a frequent faller assessment is completed after a resident has fallen as per the home's "Falls Risk Reduction Program" , to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that if the plan of care is being revised because care set out in the plan has not been effective; the licensee shall ensure that different approaches are considered in the revision of the plan of care.

Resident #022 was admitted to the home on a specific date in 2016 with multiple diagnoses. Resident #022 ambulated with a specific mobility device.
Between admission and a specific date in the summer of 2016, the resident fell fourteen times.

A Critical Incident Report was submitted to the Director under O. Reg 79/10, s. 107 (3) (4) on a specific date in July 2016 following resident #022's fall which resulted in him/her being transferred to hospital. The CIR was amended 11 days later and indicated that the resident had been diagnosed with a specific medical condition.

A review of the resident's health care record indicated that eight falls were related to resident #022's toileting needs:

On a specific date in 2016 at a specific time, the resident was found sitting upright on the floor of his washroom. Resident #022 reported that he had slipped on the bedspread while getting up to go to the washroom and had crawled to the washroom before calling for help. Two small abrasions on a specific body part were found.
On a specific date in 2016 at a specific time, the resident was found on the floor in his/her bedroom, and there was a large amount of liquid on the floor. No injury was sustained.
On a specific date in 2016 at a specific time, the resident reported to a PSW that he/she fell in the washroom after slipping on urine. No injury was sustained.
On a specific date in 2016 at a specific time, the resident was found on the floor in the hallway and reported that he/she had fallen in the washroom and scooted to the hallway to call for help. The resident's brief was saturated with urine and urine was found on the floor. He/she had sustained injury to three different specific body parts.
On a specific date in 2016 at a specific time, the resident reported that he/she had fallen in his/her room. Urine and a few drops of blood were found on the floor in the resident's washroom. Approximately 2.5 hours later, resident #022 was found on the floor sitting in a puddle of urine.
On a specific date in 2016 at a specific time, the resident was found on the floor, in a co-resident's room. He/she had been incontinent of urine and his/her incontinence product was slightly pulled down. Resident #022 complained of a sore specific body part where a large bump was found along with some blood. A progress note entry stated that earlier in the shift, a PSW had reported that the resident had a bump on a specific body part and had found blood on the resident's bed, however there was no previous report of a bump on this specific body part.
On a specific date in 2016 at a specific time, the resident was found on the floor in his/her room. He/she had gotten up to go to the washroom. The resident complained of pain, was retching and spitting phlegm and had an injury to a specific body part. The resident was sent to the hospital. A diagnostic testing revealed an injury to a specific body part. He/she returned to the home three days later.

A review of resident #022's care plan indicated that he/she was at risk for falls, and fall prevention interventions were in place. There was no indication in the care plan that a specific toileting schedule/program was implemented for resident #022 when he/she fell eight times related to toileting between admission and a specific date in the summer of 2016. On a specific date the following two interventions were added to the care plan: toilet once during the night as an attempt to decrease falls (on a specific date the physician wrote this as an order and stated that it was at the family's request) and toilet

every two hours when awake.

The home's Falls Risk Reduction Program (ICPG-006), under Intervention Strategies: G) continence management states to assess the resident for bowel/bladder program / toileting routine to decrease urgency/incontinence.
[s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Falls Risk Reduction Program related to continence management is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

On a specific date in the fall of 2016, resident #019 fell in his/her room and sustained an injury which resulted in altered skin integrity for a specific body part for which he/she required to be sent to the hospital. The resident returned to the home the same day with a specific treatment.

Inspector #550 reviewed the resident's health care records. Although there was documentation of the injuries in the progress notes, the inspector was unable to find any documentation indicating that a skin assessment was conducted using a clinically appropriate assessment instrument.

During an interview, RPN #110 indicated that skin assessments are to be completed using the skin assessment tool in PCC for each resident on admission, quarterly, upon a return of a leave of absence or hospital stay and when there is a change in the resident's condition. She further indicated that resident #019 should have received a skin assessment when he/she suffered altered skin integrity following a fall and that she was unable to find any documentation supporting that a skin assessment had been completed.

During an interview, the Director of Care indicated to the inspector that a skin assessment should have been completed for resident #019 after he/she suffered altered skin integrity following his/her fall but that it was not completed.

As evidenced above, resident #019 who suffered altered skin integrity after a fall, did not received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.
[s. 50. (2) (b) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents who are exhibiting altered skin intergrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to resident #024 in accordance with the directions for use specified by the prescriber.

On a specific date in the fall of 2016, resident #024 was assessed by the MD due to an edematous specific body part with pain on palpation. The MD diagnosed the resident with a specific diagnosis and ordered a specific anticoagulant therapy with specific directions. Four days later, the MD ordered another anticoagulant to be taken by mouth twice daily, and the times of administration according to the MAR were 0800 and 1600.

On another specific date in the fall of 2016, a specific narcotic was ordered to be administered twice daily and every four hours as needed. The times of administration for the narcotic according to the MAR were 0800 and 2000.

According to resident #024's SDM, he/she was informed that on three occasions, the resident did not receive the oral anticoagulant as prescribed, and on one occasion, the resident did not receive the specific narcotic as ordered.

During an interview with RN #104, she stated that resident #024 did not receive the oral anticoagulant on three specific dates and time, and did not receive the narcotic on a specific date and time. The RN stated that the three tablets of the oral anticoagulant medication and one tablet of the narcotic were found to be still in the blister packs. Medication Incident Reports confirmed that the resident did not receive his/her medications as prescribed as indicated above. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.

Resident #017 sustained a fall on a specific date in the summer of 2016, which resulted in multiple fractures for which the resident required to have surgery. The resident returned to the home eight days later. Upon a review of the resident's health care records, it was observed that the resident had lost 5.9kg over a specific period of time; 8.9 per cent change in his/her body weight in one month. The inspector was unable to find any documentation to indicate that the resident was assessed by the dietician.

During an interview, the Dietician indicated to the inspector that residents with weight changes greater than five per cent in their body weight in a month is communicated to her through an alert in the Point Click Care software. She indicated resident #017 should have been assessed when there was a change greater than five percent in his/her body weight. She indicated she did not assess the resident due to time constraints.

As evidenced above, resident #017 was not assessed by the Dietician when there was a change of more than 5 per cent in his/her body weight over one month.
[s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Issued on this 6th day of January, 2017

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

Original report signed by the inspector.