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
Apr 18, 2017	2017_582548_0006	005938-17	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

RUZICA SUBOTIC-HOWELL (548), LISA KLUKE (547)

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): April 3, 4, 5, 6, 7,10 and 11, 2017

The following critical incident inspections were conducted concurrently during this Resident Quality Inspection:

Log#: 003359-17, related to improper care
Log#: 001055-17 and Log#: 000090-17, related to alleged incidents of staff to resident abuse
Log#: 006435-17, related to alleged incident of resident to resident sexual abuse
Log#: 006735-17, related to a fall
Log#: 000603-17, related to an unexpected death

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Resident Care Coordinators (RCCs), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers, (PSWs), MDS-RAI Coordinator, Residents, Family members, Chairperson of Family Council, Resident Council Liaison, Maintenance Manager and Maintenance worker.

During the course of the inspection the inspectors toured the home, observed resident care being provided, medication administration pass and infection prevention and control practices. The inspectors reviewed resident health care records, resident and family council general meeting minutes and home related policies related to doors, the prevention of abuse program, urinary and bowel assessment, narcotic count, Geriatric Mental Health reports and mandatory critical incident reporting. The inspectors reviewed documentation related to the home's investigation notes into the above critical incidents.

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
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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 O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The Licensee failed to ensure drugs are secure and locked.

On April 6, 2017 on a unit-3A at 0848 hours Inspector #548 observed the medication cart to be left unlocked and unattended at the entrance of the dining room. The majority of residents from the unit were in the dining room for breakfast service.

The Inspector #548 observed prescribed ointment for resident #026 to be resting on the top of the medication cart. The cart was also unlocked. All drawers were opened by the Inspector to reveal resident specific prescribed medication in strips, liquids and injectables.

At 0850 RPN #116 returned to the cart from the servery. During an interview on April 6, 2017 she indicated that she had left the cart out of her sight to refill a water jug. RPN #116 indicated that she keeps all drugs on the top of the cart as a reminder of what needs to be reordered. RPN #116 indicated that she is aware to ensure all drugs are safe and secure and that the cart is to be locked in her absence, as per home policy.

At 0913 hours the inspector #548 observed that the same ointment for resident #026 to remain on the top of the cart. The RPN #116 was in the dining room with some of the residents and the cart in her view.

At 0920 hours on a unit-3B the inspector #548 observed the medication cart to be

unlocked and unattended alongside room 312-1. On top of the cart was a medication cup containing several white round tablets, one white cylindrical tablet and one round orange tablet. In addition, one container of eye gtts for resident #027 was resting on the top of the medication cart. Each drawer was easily accessible and opened for the Inspector. As on unit 3A, all drawers were opened by the inspector to reveal resident specific prescribed medication in strips, liquids and injectables.

Inspector #548 observed RPN #117 in a resident room facing resident #019. The RPN #117 returned to the cart. During an interview on April 6, 2017 RPN #117 indicated that she had prepared the medication for resident #027 and left them on top of the medication cart prior to attending to resident #019 where she administered the morning medication. RPN #117 indicated that she is aware that all medications are to be kept safe and locked.

On April 7, 2017 on unit-3A at 1240 hours inspector #548 observed the medication cart to be in front of the dining room and a tube of prescribed gel on top of the medication cart for resident #029. The medication cart was unattended. Residents were in the vicinity of the medication cart. Inspector #548 observed RPN #116 return to the cart from down the hallway. There are two previous observations where drugs were not secure and locked related to RPN #116. [s. 129. (1)]

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 all drugs are safe and secure at all times, to be implemented voluntarily.

WN #2: 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 failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan for resident #022.

Related to Log#: 003359-17

A critical incident was submitted regarding an incident that resulted in an injury to resident #022. The resident was found on the floor with sustained injuries.The licensee's initial investigation found that the resident's bed was at a higher height than usual as a contributing factor to the cause of the fall incident.

The resident's #022 health care record was reviewed related to the incident.

Review of the resident's post fall assessment indicated that the predisposing factors identified that the bed was raised so that the personal support worker (PSW) could provide care to the resident. The resident was confused and attempted to get up on thier own after the PSW left the room.

Inspector #548 reviewed resident's #022 current care plan. The care plan specifies that the resident requires total assistance and specified fall prevention interventions to include bed to be at resident specific height at all times and to ensure the bed alarm monitor is secured to resident, while in bed at all times.

On April 6, 2017 during an interview with inspector #548 the resident's family member indicated that she was informed by management that a PSW #126 left to answer another co-resident's call bell leaving the resident in the bed at the highest position with no posey alarm attached.

On April 7, 2017 during an interview with inspector #548 PSW #126 indicated that she had left the resident unattended with the bed to the highest position and with no alarm attached to attend to another co-resident as requested by a registered staff member. She indicated that she is aware of the resident care needs as per the plan of care.

On April 6, 2017 Resident Care Coordinator #114 indicated that resident specific height of the bed was to be at the lowest position.She indicated that PSW #126 was disciplined as a result of the incident. [s. 6. (7)]

WN #3: 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 their policy: Building security, H-095, review date: September 23 2016 is complied with.

As per O. Reg. 79/10. s. 9 (2) the licensee is to ensure that there that there is a written policy that deals with when doors leading to secure outside areas are unlocked or locked to permit or restrict unsupervised access to those areas by residents.

The home's policy: Building security, H-095, review date: September 23 2016 was provided to the inspector from the Maintenance manager. The policy indicates that terraces and gardens door are to be locked from Labor day to Good Friday.

On April 3, 2017, eleven days prior to Good Friday, Inspector #548 observed on unit 3-A a door leading directly from the dining room to a secure outside balcony. The inspector found the door to be equipped with a lock, an alarm and manual reset panel. The inspector #548 found the door to be unlocked and ajar at 1039 hours. At the time of the observation a housekeeper was washing the floor in the dining room. The inspector #548 sought out a registered staff member.

During an interview on April 3, 2017 RPN #110 indicated that all staff have a key to unlock the door so that residents may gain access to the balcony. She indicated that the staff member is required to lock the door when the resident returns inside. RPN #110 indicated that PSW #105 had unlocked the door.

During an interview on April 3, 2017 at 1050 hours PSW #105 indicated that she has a key to unlock the door and had done so after breakfast meal service at approximately 1000 hours so that she could gain entry to the balcony. PSW #105 indicated that she had left the door unlocked and returned to the unit to restock supplies. She indicated she had left the door ajar and would have returned before lunch service to close and lock the door.

During an interview on April 3, 2017 the maintenance manager indicated that the home does not open doors to the balcony until a specified time of the year. He indicated that the doors to the balcony for resident use could be opened after April 14, 2017, as per the home's policy and weather permitting. [s. 8. (1)]

Issued on this 18th day of April, 2017

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

Original report signed by the inspector.