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 # / No de registre	Type of Inspection / Genre d'inspection
Jul 10, 2018	2018_741178_0007	025385-17	Complaint

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

SUSAN LUI (178)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 25, 28, 29, 30, 31, 2018.

During the course of the inspection, the inspector(s) spoke with residents, a family of a resident, Personal Support Workers (PSWs), a Food Service Worker, a Registered Practical Nurse (RPN), a Registered Nurse (RN), a Resident Care Coordinator (RCC), the Director of Care (DOC).

During the course of the inspection, the inspector also observed a meal service, observed resident care, reviewed resident health records and reviewed home records.

The following Inspection Protocols were used during this inspection:
Dining Observation
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 ensure that resident #001's plan of care set out clear directions to staff and others who provided direct care to the resident.

On May 30, 2018, Resident Care Coordinator (RCC) #103 indicated that residents' plans of care include progress notes, the care plan, the unit communication book, medication administration records, physician orders, and the treatment book which contains treatment administration records.

Resident #001's health record was reviewed. Resident #001 was admitted to the home several years ago, and required assistance with mobility and activities of daily living.

Resident #001's plan of care in place on an identified date, indicated that the resident was to have an identified body part assessed every three months, and if needed, it was to be treated with an identified treatment. The plan of care also indicated that after assessment there should be follow up with the Nurse Practitioner, the Resident Care Coordinator and the Power of Attorney (POA). The plan of care further indicated that as of an identified date, an identified treatment was to be provided for the identified body part for five days. Resident #001's health record included a progress note by RCC #103, on an identified date, which indicated that the resident's identified body part had been assessed, and that the resident and POA agreed to a specific treatment, but specifically declined another identified treatment at this time. An order written on the same identified date, documented on the physician's order sheet, documented the agreed upon treatment, and is signed as a telephone order from the Nurse Practitioner (NP). A progress note dated four days later, and written by RCC #103, indicated that the RCC

was able to complete the treatment successfully. However, a progress note written by the Nurse Practitioner (NP) one day after RCC #103's note, indicated that a different treatment was ordered; one which had been specifically declined by resident #001's POA. A progress note by RN #104 one day after the NP's note, indicated the treatment the NP referred to was completed as per protocol, and that the resident demonstrated discomfort near the end of the procedure.

During an interview with Inspector #178 on May 29, 2018, RN #104 indicated that on an identified date, RN #104 assessed resident #001's identified body part and determined that treatment was necessary. RN #104 then carried out an identified procedure without checking with the resident's POA prior to this procedure, as instructed on the plan of care. RN #104 and was not aware that the POA and resident had declined this specific procedure six days prior. RN #104 indicated that they checked resident #001's care plan prior to conducting the procedure, and saw that the order for the procedure remained. RN #104 did not see the notes written several days prior, indicating that the RCC had already successfully treated the resident's identified body part using a procedure agreed upon with the resident's
POA.

During an interview with Inspector #178 on May 30, 2018, the DOC indicated that there was a communication error when RN #104 conducted an identified procedure for resident #001 on an identified date. The DOC indicated that RN #104 took direction from a progress note written by the NP which stated the identified procedure was ordered. The DOC indicated that RN #104 should have confirmed how to proceed before conducting the identified procedure for resident #001. The DOC indicated that RN #104 should have checked the resident's care plan and not acted simply as a result of a progress note.

In conclusion, the licensee failed to ensure that resident #001's plan of care set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

a) As noted above, resident #001's plan of care on an identified date, indicated that the resident was to have an identified body part assessed every three months.

During interview with Inspector #178 on May 29, 2018, RN #104 indicated that it would

be their responsibility to conduct the assessment of resident #001's identified body part every three months, but was unsure whether or not this assessment had been completed every three months, especially more recently. RN #104 indicated that in past years, resident #001's identified body part was assessed more regularly, but in the more recent past, they were unsure of what resident #001's POA wanted done for the resident, so they would try to check with the POA before any procedures were carried out. RN #104 indicated that as a result, resident #001's identified body part may not have been assessed every three months more recently.

During an interview with Inspector #178 on May 29, 2018, RCC #103 indicated that resident #001's identified body part was to be assessed every three months, and that when this assessment is conducted it should be documented in a progress note. RCC #103 indicated that on review, no progress notes regarding assessment of the resident #001's identified body part could be found within an identified two year period, even though the resident's identified body part was supposed to be assessed every three months during that period. RCC #103 indicated that resident #001's plan of care was not followed with regards to assessment of the identified body part.

b) Resident #001's plan of care for Eating Ability, in place on an identified date, included four identified interventions with regards to food preferences, positioning, use of assistive devices and clothing protection.

According to a Resident/Family Concern Report, completed by the licensee on an identified date, resident #001's POA expressed concerns that during the supper meal on the prior day, the POA observed that the above four identified interventions for resident #001 were not followed.

During an interview with inspector #178 on May 31, 2018, RPN #106 indicated that they worked on resident #001's unit on the evening when resident #001's POA expressed concerns that the resident's plan of care with regards to eating was not followed. RPN #106 was unsure whether or not resident #001 was provided with an assistive eating device on the evening in question, and indicated that resident #001 did not normally use assistive devices for meals. Further, RPN #106 indicated that they did not position resident #001 as per their plan of care because RPN #106 felt this positioning was contraindicated by general direction they received from physiotherapy in the past. RPN #106 could not recall whether or not resident #001's plan of care was followed regarding clothing protection and food preferences on the date in question. RPN #106 indicated that the unit was short one staff member that evening, and that some errors were made

regarding following resident #001's plan of care.

During an interview with Inspector #178 on May 29, 2018, RCC #103 indicated that resident #001's substitute decision maker (SDM) had lodged concerns on an identified date, regarding the supper meal service the prior evening. RCC #103 indicated that the SDM observed that four identified interventions with regards to food preferences, positioning, use of assistive devices and clothing protection were not completed for resident #001 as per the resident's plan of care. RCC #103 indicated that the unit was short staffed that evening due to staff illness, and nobody could be found to replace, so various staff members came to the unit for thirty minutes at a time to assist, which resulted in a lack of continuity of care. RCC #103 indicated that resident #001's plan of care with regards to eating should have been followed.

In conclusion, the licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan. [s. 6. (7)]

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 care is provided to residents as specified in the plan, to be implemented voluntarily.

Issued on this 25th day of July, 2018

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

Original report signed by the inspector.