Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 24, 2020	2020_770178_0001	020599-19, 024327-19	Critical Incident System

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): January 15, 16, 17, 21, 2020.

The following Critical Incident Logs were inspected:
020599-19/CIR #M621-000037-19 and 024327-19/CIR #M632-000042-19, both regarding a improper/incompetent treatment of a resident that results in harm or risk to a resident.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers, Registered Practical Nurses, Registered Nurses, the Registered Dietitian, RAI Coordinators, and the Director of Care.

During the course of the inspection, the inspector also reviewed resident health records, records of internal investigations, and licensee policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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	Légende 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 ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan related to falls prevention.

Critical Incident Report (CIR) #M621-000037-19 indicated that on an identified date, resident #001 was found on the floor beside their bed. The CIR indicated that the resident appeared to have rolled out of bed onto the floor and was not injured. The bed was found to be at average height, but the resident's plan of care stated that the bed was to be in the lowest position.

The plan of care for falls prevention for resident #001 indicated that the resident's bed was to be maintained at the lowest position.

RPN #101 and PSW #103 both indicated to Inspector #178 that when resident #001 was found on the floor on the identified date, the resident's bed was not in the lowest position as per the resident's plan of care.

As such, the licensee 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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 when resident #002 exhibited altered skin integrity, specifically a pressure ulcer, the resident 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.

A progress note written by RN #111 for resident #002 indicated on an identified date, that the resident had a pressure ulcer in an identified location. During an interview with RN #111, they indicated that when a resident has a pressure ulcer, they should be assessed using the Pressure Ulcer Scale for Healing (PUSH) Tool, in which the width, length, drainage, colour, and granulation of the wound is used to calculate its PUSH score. RN #111 indicated that they did not use the PUSH tool to assess resident #002's wound, as per the licensee's policy.

On an identified date approximately three weeks later, a progress note for resident #002 indicated a higher staged ulcer in the same location. Resident #002's health record was reviewed and no PUSH Tool was present documenting an assessment of the resident's pressure ulcer.

The Director of Care indicated that a PUSH tool should have been used to assess resident #002's pressure ulcer, and the assessments documented on the tool. The DOC was unable to find any record of the PUSH tool in resident #002's health record. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that when resident #002 exhibited altered skin integrity, specifically a pressure ulcer, they were assessed by a registered dietitian who is a member of the staff of the home.

Resident #002's progress notes indicated that the resident had a pressure ulcer. The resident's record contained no documentation to indicate that resident #002 was assessed by a Registered Dietitian (RD) after the impaired skin integrity was identified.

During an interview, the RD indicated that they were not notified of resident #002's impaired skin integrity, and did not assess the resident's nutrition needs with regards to their impaired skin. [s. 50. (2) (b) (iii)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
-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
-is assessed by a registered dietitian who is a member of the staff of the home, 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 any actions taken with respect to resident #002 under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

In accordance with O. Reg. 79/10, s. 48(1), the licensee was required to ensure that a skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions, was developed and implemented in the home.

Progress notes for resident #002 indicated that on an identified date, the resident had a newly identified pressure ulcer in an identified location. RPN #115 who works full time on resident #002's unit, indicated that they reassessed the resident's pressure ulcer every shift after it was initially identified, and that the assessments should have been documented in the resident's progress notes.

The DOC indicated that registered nursing staff are expected to reassess a resident’s wound at least weekly, and should document their assessments either on the PUSH wound assessment tool, or in the resident’s progress notes.

Resident #002's health record was reviewed. No PUSH wound assessment tool was present in the health record. Resident #002's progress notes contained documentation of only two assessments of resident #002's impaired skin in the 23 days after the pressure ulcer was first identified.

As such, the licensee has failed to ensure that any actions taken with respect to a resident under a program, including reassessments, were documented. [s. 30. (2)]

Issued on this 3rd day of February, 2020

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

Original report signed by the inspector.