Ontario

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

Inspection Report under the
Fixing Long-Term Care Act, 2021

Ottawa Service Area Office
347 Preston Street, Suite 420
Ottawa ON K1S 3J4
Telephone: 1-877-779-5559
OttawaSAO.moh@ontario.ca

Original Public Report

Report Issue Date September 7, 2022
Inspection Number 2022_1616_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
The Corporation of the County of Renfrew

Long-Term Care Home and City
Miramichi Lodge, Pembroke

Lead Inspector
Karen Buness (720483)

Additional Inspector(s)
Marko Punzalan (742406)

Inspector Digital Signature
Karen Lynne Buness
Digitally signed by Karen Lynne Buness
Date: 2022.09.08 11:01:07 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 18, 19, 23, 24, 25, 26, 29, 30, 31, 2022

The following intake(s) were inspected:

- Intake #015427-22 (Complaint) related to alleged neglect of a resident
- Intake #010733-22 (CIS #M621-000010-22) related to a resident fall which resulted in transfer to hospital
- Intake #013625-22 (CIS # M621-000023-22) related to alleged neglect of a resident

The following **Inspection Protocols** were used during this inspection:

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Resident Care and Support Services

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INSPECTION RESULTS

WRITTEN NOTIFICATION- NOTIFICATION RE INCIDENTS

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 104 (1) (b)

The licensee has failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Rationale and Summary
The licensee submitted a Critical Incident to the Ministry of Long-Term Care to report alleged abuse and neglect of multiple residents. Day staff reported the night staff did not perform change rounds on them. The Prevention of Abuse or Neglect Policy states the resident's Substitute Decision-Maker or Power of Attorney (POA) shall be notified immediately upon the Administrator/designate becoming aware of an alleged, suspected or witnessed incident of abuse or neglect that resulted in physical injury or pain, or distress that has the potential to be detrimental to the resident's health/wellbeing and within 12 hours of any other alleged, suspected or witnessed incident of abuse and neglect. The Director of Care reported the home did not contact the Substitute Decision Makers/POA's to notify them of the incident.

Sources: Interview with Director of Care and Personal Support Worker, Prevention of Resident Abuse and Neglect Policy- Date Last Revised: March 31, 2022.

(720483)

WRITTEN NOTIFICATION- POLICY TO PROMOTE ZERO TOLERANCE

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 25 (1)

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with.

Rationale and Summary
A resident's POA made a complaint of alleged neglect to the home. The Prevention of Resident Abuse or Neglect policy directs the Administrator and/or the Department Supervisor to advise the resident or Substitute Decision Maker/Power of Attorney for Personal Care of the outcome of the investigation and the corrective actions taken. The Director of Care stated the strategies towards preventing re-occurrence had not been shared with the POA. The resident's POA confirmed the home did not follow up after the incident to discuss the outcome of the investigation or the corrective actions taken.

Sources: Interview with the Director of Care and POA, Prevention of Resident Abuse and Neglect Policy- Date Last Revised: March 31, 2022.

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WRITTEN NOTIFICATION- BEDTIME AND REST ROUTINES

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 45

The licensee has failed to ensure that each resident of the home has the resident's desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

Rationale and Summary
The home failed to ensure a resident's rest period was provided as directed in the plan of care. Interviews with Personal Support Workers (PSW) on shift the day of the incident revealed the resident did not receive afternoon care. Two additional PSW's reported the resident's afternoon care includes an afternoon nap. An interview with an RPN confirmed the resident's preferred nap is included in the resident's plan of care.

Sources: Interview with Registered Practical Nurse, Personal Support Workers, the residents clinical record plan of care.

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