Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
February 16 & 17, 2011	2011-117-9506-+16Feb124530	Critical Incident Log # O-000139 and #O-000164

Licensee/Titulaire

County of Renfrew
9 International Drive
Pembroke, Ontario
K8A 6W5
Fax: 613-735-2081

Mailling address:
470 Albert Street
Renfrew, Ontario
K7V 4L5

Long-Term Care Home/Foyer de soins de longue durée

Bonnechere Manor
470 Albert Street
Renfrew, ON
K7V 4L5
Fax: (613) 432-7138

Name of Inspector(s)/Nom de l'inspecteur(s)

Lyne Duchesne #117

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection related to the care and services provided to two identified residents.

During the course of the inspection, the inspector spoke with the home's Administrator, the Director of Care, to a Registered Nurse, to two Registered Practical Nurses, to a Personal Support Worker and to two identified residents.

During the course of the inspection, the inspector reviewed two identified residents' health care records, reviewed the home's policies and procedures on Continence Care – Bowel and Bladder Management (#N-10-013), on Zero Lift Policy (#N-15-002), on Over-bed Logo System (#N-15-0003) and on Lifts and Transfers Assessment (#RC-002); reviewed the home's Mandatory In-services binder and examined two resident rooms as well as the connecting bathroom between the rooms.

The following Inspection Protocols were used during this inspection:

- Continence Care and Bowel Management
- Fall Prevention

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN
2 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s6 (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.

Findings:

1. An identified resident is diagnosed as having advanced dementia and requires 2-person mechanical lift transfer for repositioning in and out of bed as well as for toileting on the commode. The resident's plan of care indicates that the resident requires total assistance during toileting and staff needs to ensure resident safety.

2. A second identified resident is diagnosed as having advanced dementia and requires 2-person transfer assistance for repositioning in and out of bed as well as for toileting on the commode. The resident's plan of care indicates that the resident requires total assistance during toileting and staff needs to ensure resident safety.

3. On January 16 2011, two Personal Support Workers transferred one identified resident to a commode. They seated the resident on the commode and pushed the commode beside the resident's bed. The resident was seated facing the side of the bed. The resident's hands were placed on the elevated side rails.

4. The resident was left unattended on the commode by the two Personal Support Workers when the Personal Support Workers went to toilet the second identified resident, who was located in the room adjacent to first resident's room.

5. The Personal Support Workers transferred the second resident to a commode for toileting. The Personal Support Workers heard a loud noise in first resident's room. The two Personal Support Workers left the second resident on the commode, unattended, to attend the first resident.

6. The first resident was found lying on the floor. The commode was pushed back from its position beside the bed. Registered Nursing staff were called to assess the resident. The resident was noted to have pain to the right leg, no other injuries were noted at that time. During this time, the second resident was left unattended on the commode.

7. However, on January 18, 2011 the first resident was transferred to hospital and was diagnosed as having a fractured right hip.

8. The Registered Practical Nurse and the Registered Nurse state when they arrived to assess the fallen resident, the two Personal Support Workers admitted to leaving the resident unattended on the commode, while they left the resident's room to toilet the second resident. They also admitted that they had left the second resident unattended when they left the room after hearing a noise in first resident's room.

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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 regarding the need to ensure that that toileting routines set out in the plan of care for two identified residents is provided to the residents as specified in the plan, to be implemented voluntarily.

WN #2: The licensee has failed to comply with O.Reg. 79/10, 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,

(b) and is complied with.

Findings:

1. The Ontario Regulations 79/10 made under the Long-Term Care Homes Act, 2007, requires that the licensee have a continence care and bowel management program (O.Reg. s.48 (1) (3)).

2. The Licensee's policies regarding continence care (SOP#: N-10-013) identifies that during toileting interventions, staff "Do not leave any resident requiring support in a sitting position unattended".

3. An identified resident is diagnosed as having advanced dementia and requires 2-person mechanical lift transfer for repositioning in and out of bed as well as for toileting on the commode. The resident's plan of care indicates that the resident requires total assistance during toileting and staff needs to ensure resident safety.

4. A second identified resident is diagnosed as having advanced dementia and requires 2-person transfer assistance for repositioning in and out of bed as well as for toileting on the commode. The resident's plan of care indicates that the resident requires total assistance during toileting and staff needs to ensure resident safety.

5. On January 16 2011, two Personal Support Workers transferred one identified resident to a commode. They seated the resident on the commode and pushed the commode beside the resident's bed. The resident was seated facing the side of the bed. The resident's hands were placed on the elevated side rails.

6. The resident was left unattended on the commode by the two Personal Support Workers when the Personal Support Workers went to toilet the second identified resident, who was located in the room adjacent to first resident's room.

7. The Personal Support Workers transferred the second resident to a commode for toileting. The Personal Support Workers heard a loud noise in first resident's room. The two Personal Support Workers left the second resident on the commode, unattended, to attend the first resident.

8. The first resident was found lying on the floor. The commode was pushed back from its position beside the bed. Registered Nursing staff were called to assess the resident. The resident was noted to have pain to the right leg, no other injuries were noted at that time. During this time, the second resident was left unattended on the commode.

9. However, on January 18, 2011 the first resident was transferred to hospital and was diagnosed as having a fractured right hip.

10. The Registered Practical Nurse and the Registered Nurse state when they arrived to assess the fallen resident, the two Personal Support Workers admitted to leaving the resident unattended on the commode, while they left the resident's room to toilet the second resident. They also admitted that they had left the second resident unattended when they left the room after hearing a noise in first resident's room.

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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, where the licensee is required to ensure that the policy regarding continence care for the two identified residents is complied with, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. Lyne Duchesne
Title: Date:	Date of Report: (if different from date(s) of inspection). March 1, 2011