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 prévue le Loi de 2007 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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Sep 10, 2018;	2018_593573_0010 (A1)	010776-18	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

Bonnechere Manor
470 Albert Street RENFREW ON K7V 4L5

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

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

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

Amended by ANANDRAJ NATARAJAN (573) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

This report has been revised that Compliance Order #001 and #002 in inspection report 2018_593573_0010 have been rescinded based on the review of the information submitted by Bonnechere Manor and the Warden of the County of Renfrew.

Issued on this 10 day of September 2018 (A1)

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

Original report signed by the inspector.

Ontario

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

Amended by ANANDRAJ NATARAJAN (573) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): June 04, 05, 06, 07, 08, 11, 12, 13, 15, 18, 19, 20, 21 and 22, 2018.

The following Critical Incident and Complaint inspections were conducted concurrently during this Resident Quality Inspection:

Critical Incident Logs #003756-18 and 003759-18, were related to improper care of a resident that results in risk to a resident.

Logs #000267 -18 and 006619-18, were inspected related to an incident that caused an injury to a resident for which resident was transferred to hospital.

Log #000116 -18, related to alleged incident of resident to resident physical abuse.

Log #005082 -18, related to alleged incident of staff to resident physical and verbal abuse.

Log #000256 -18, related to Fall incident.

Log #027302 -17, related to Disease Outbreak.

Complaint Log #001982 -18, related to admission to the Long-Term Care home.

During the course of the inspection, the inspector(s) spoke with the residents, family members, a member of Residents' Council, Chair of Family Council, Housekeeping Staff, Maintenance Staff, Food Service Workers, Recreation Assistant, Rehabilitation Assistant, Behavioural Support Ontario (BSO) Staff, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Administration Supervisor, the Client/Outreach Programs Supervisor, the Food Service Supervisor (FSS), the Environmental Services Supervisor (ESS), Resident Care Coordinators (RCCs), the Director of Care (DOC), the Director of Long-Term Care.

During the course of the inspection, the inspector(s) completed a tour of resident areas, observed medication storage areas, observed meal and snack services, observed medication administration, reviewed medication incident documentation, reviewed Residents' and Family Councils meeting minutes, reviewed resident health records, reviewed staff training records, reviewed home's menu cycle, reviewed relevant home policies, protocol and procedures, reviewed critical incident reports and documents related to the licensee's investigation into the identified alleged incidents of abuse.

In addition Inspectors observed the provision of care and services to the residents, staff to resident interactions and resident to resident interactions.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Safe and Secure Home

During the course of the inspection, Non-Compliances were issued.

- **7 WN(s)**
- **4 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. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that interventions to minimize the risk of altercations and potentially harmful interactions between residents were identified.

On an identified date and time, the charge RN of the Home contacted the Ministry of Health and Long -Term Care (MOHLTC) after-hours pager to report an incident of alleged resident to resident physical abuse. Following day a Critical Incident Report (CIR) was submitted to the MOHLTC. A review of the CIR indicated that on an identified date, prior to the dinner hour resident #043 was becoming verbally aggressive and began threatening the registered staff on the unit. At an identified hours, staff entered the resident's room and found resident #048 with blood and injuries to resident #048's specific body parts. Resident #048 was transferred to hospital for treatment and returned to the home in stable condition with specified diagnosis. Resident #043 was transferred to hospital with the police.

Resident #043 was admitted to the home with cognitive impairment and responsive behaviours related to multiple diagnosis.

Resident #048 was admitted to the home with cognitive impairment related to diagnosis.

Inspector #142 reviewed resident #043's progress notes, which indicated that resident #043 demonstrated responsive behaviours such as increased agitation/ verbal aggression towards resident #048 on multiple occasions.

On an identified date, on three different occasions resident #043 exhibited increased agitation/verbal aggression towards their roommate resident #048. Resident #043 verbally threatening to cause physical harm to their roommate. The resident was given medications for responsive behaviours. Resident #043 was offered choices to come to lounge, sit at nursing station or stay in room and reminded to remain on to stay on their side of the room. Staff were directed to make more frequent checks for safety of both residents. BSO referral was sent and DOS mapping initiated. On the same day, resident #043 was assessed by the BSO team and Royal Ottawa Hospital paperwork faxed to physician for completion.

Five days later, on three different occasions resident #043 exhibited increased agitation/verbal aggression towards their roommate resident #048. Registered nursing staff redirected the resident's attention. Safety huddle was performed with PSWs and staff were advised to monitor the resident every 15 minutes and report

any further behaviour and to keep co-resident of out room. The RN noted in the progress note that the resident did not mean they were going to cause physical harm however resident #043 was frustrated with co-resident. The RN further indicated in the progress notes that staff were aware of the resident's increased behaviours and aware to report any physical or verbalizations of harm towards self or roommate.

Six days later, during the day shift, resident #043 had elevated responsive behaviour in the morning and was given medications. Resident #043 remained in the room throughout the shift and continued to express anger at multiple issues including roommate. Staff continued to check whereabouts every 15 minutes while their roommate was resting in bed.

Seven days later, physician in to assess and order received to consult geriatric mental health.

Approximately one month after on an identified date, during the evening shift it was noted by the RPN that resident #043 had increased behaviours. At a specified hours the resident left their room angrily, complaining their roommate. Resident #043 complained that staff needed to get resident #48 out from their room. Call bell were answered 36 times in 20 minutes. At a specified hours, resident #043 was shouting and making a fist at the registered staff and said "are you gonna make me hurt someone". Resident #043 was provided with medications for responsive behaviours. When RN approached the resident, resident #043 stated that none of this would be happening if didn't have to live with their roommate. RN advised staff to place the resident and roommate on 15 minute checks for safety. The physician was contacted and medication was ordered.

On an identified date, resident #043 was noted to have increased responsive behaviours around evening hours. Resident #043 was threatening registered nursing staff and roommate. The resident was provided with medications to help decrease behaviours. The RN noted that 30 minute checks would be initiated as a safety measure for other resident. On the same day on a specified hours, RN entered the resident's room and found resident #048 with blood and injuries to resident's specific body parts. Resident #048 was transferred to hospital for treatment and returned to the home in stable condition with specified diagnoses.

Resident #043 was transferred to hospital with the police and was later discharged from the home on an identified date.

Inspector #142 attempted to interview resident #048, but the resident was non-interview able.

Inspector #142 conducted separate interviews with RPNs #102, #128, #129, #135, RN #134, RCC #124, RCC #133 and the DOC and all indicated that resident #043 did not have any previous incidents of physical altercations with co-residents. RPNs #102, #128, #129, #135 and RN #135 indicated that resident #043 would exhibit behaviours when co-residents made noises and was not tolerant of residents with dementia. All staff interviewed indicated that resident #043 required a strict routine such as ensuring they received medication on time or the resident would start exhibiting increased agitation/verbal aggression responsive behaviours.

In addition, when staff were interviewed by Inspector #142, they further indicated that when resident #043 exhibited behaviours towards other residents, staff would re-direct resident #043 away from co-residents, remove co-residents from resident #043 and provide medication for increased agitation. When asked specifically what interventions staff had in place to minimize interactions between resident #043 and #048 staff indicated that they would keep resident #048 out of the room and check on residents every 15 minutes. No additional interventions were put in place to minimize the risk of altercations and interactions between resident #043 and #048.

The plan of care for resident #043 which was in place at time of the incident was reviewed by Inspector #142. The plan of care did not include any interventions for the ongoing monitoring and interventions to manage resident #043's responsive behaviours directed towards resident #048 or any other residents.

Resident #048 plan of care, in place at the time of incident was reviewed and there were no noted documented interventions developed to minimize the risk of altercations between resident #043 and #048.

On June 21, 2018, in an interview with the DOC and in reviewing resident #043 plan of care it was confirmed that plan of care did not identify interventions for the management of resident's behaviours related to resident #048 or any other residents. (Log #000116-18) [s. 54. (b)]

Additional Required Actions:

(A1)The following order(s) have been rescinded:CO# 001

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 steps are taken to minimize the risk of physical altercations between and among residents by identifying and implementing interventions, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #049, #050, #51, #052, #053, #054, and #055 were protected from physical abuse by anyone.

Ontario Regulation 79/10 of the Long -Term Care Home's Act defines physical abuse in part, as the use of physical force by anyone other than a resident, that causes physical injury or pain, and that physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances.

Critical Incident Report (CIR) which was submitted by the licensee to the Ministry of Health and Long-Term Care on an identified date indicated that on an identified date, PSW #125 and PSW #130 observed PSW #127 providing care to multiple residents in a rough manner. This rough care included roughly manipulating residents' extremities when dressing and undressing the residents, pulling the sling out from under one resident in a rough manner, and quickly pulling some residents along the ceiling lift track by pulling the resident by the sling, rather than using the lift's remote control. The CIR also indicated that PSW #125 and PSW #130 observed PSW #127 using profanity in front of multiple residents.

During an interview with Inspector #178 on June 15, 2018, PSW #130 indicated that on an identified date, PSW #130 witnessed that PSW #127 was rough while assisting several residents to dress or undress during care. PSW #130 indicated that they witnessed PSW #127 do the following:
-roughly pushed resident #049's forward and back in the wheelchair in order to straighten the resident's clothing and roughly removed the lift sling from under the resident. PSW #127 also cursed in front of, but not at resident #049, and quickly pushed resident #049 along the ceiling lift track while the resident was in the lift sling, rather than use the lift remote control, as per usual practice.
-threw resident #050's blanket at the resident, hitting the resident. PSW #130 indicated that resident #050 was not injured, but afterward resident #050 asked PSW#127 "why are you always mean to me".
-roughly undressed resident #051. The resident frowned in response.
-roughly removed the lift sling from under resident #052, roughly grazing the resident's body part in the process. When this happened, resident #052 grabbed their body part and expressed that it hurt.
-roughly undressed resident #055. Resident #055, who does not speak, made noises during this process, which PSW #130 felt indicated the resident was experiencing discomfort. PSW #127 also pushed resident #055 along the ceiling lift track while the
resident was in the lift sling, rather than using the mechanical lift remote control, as per usual practice.
-roughly undressed resident #053 and cursed in front of, but not at the resident. Afterward, resident #053 indicated to PSW #130 that they do not want PSW #127 in their room because PSW #127 is rough.

PSW #130 indicated to Inspector #178 that they considered PSW #127's treatment of residents #049, #050, #051, #052, #053 and #055, to be physically abusive. PSW #130 indicated that when PSW #127 went to break, they reported the physical abuse and cursing to RPN #132 and RN #131, and the registered staff ensured that PSW #127 was sent home. PSW #130 indicated that they first observed PSW #127 providing rough care to a resident when PSW #127 pushed resident #049 quickly along the ceiling lift track while the resident was in the lift sling, and then roughly pushed resident #049's upper body forward and back in the wheelchair in order to straighten the resident's clothing and roughly removed the lift sling from under the resident. PSW #130 indicated that they should have reported the abuse immediately when they first observed PSW #127 providing rough care to resident #049, however they did not, and PSW #127 went on to treat five or six

other residents roughly before they reported the abuse to the registered staff who then sent PSW #127 home. PSW #130 indicated awareness that they failed to follow the home's abuse prevention policy which requires that abuse of a resident is to be reported immediately to their supervisor and that it must also be reported immediately to the Ministry of Health and Long-Term Care.

During an interview with Inspector #178 on June 19, 2018, PSW #125 indicated that on an identified date, PSW #125 witnessed PSW #127 roughly undress resident #054, causing the resident to make a face and point to their specific body part. The resident then answered yes when PSW #125 asked resident #054 if their body part hurt. PSW #125 indicated that PSW #127 did not hurt the resident intentionally, but by working too quickly caused the resident discomfort. PSW #125 indicated that after witnessing this incident, PSW #125 accompanied PSW #130 to report the rough care to the registered staff, who then sent PSW #127 home.

During an interview with Inspector #178 on June 19, 2018, RCC #124 indicated that PSW #127 was sent home immediately after the incidents of rough care of multiple residents were reported to registered staff. RCC #124 indicated that no residents were injured, the incidents were investigated by the licensee, and the allegations of physical abuse were substantiated. RCC #124 indicated that PSW #127 is no longer employed by the licensee.

The licensee failed to ensure that residents were protected from abuse when PSW #125 failed to immediately report PSW #127's physical abuse of resident #049 to their supervisor. As a result, the licensee failed to prevent the subsequent physical abuse of residents #050, #051, #052, #053, #054 and #055 by PSW #127.

The licensee also failed to comply with:
LTCHA, s. 20 (1) the licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with. (refer to WN #5) (Log #005082 -18) [s. 19. (1)]

Additional Required Actions:

(A1)The following order(s) have been rescinded:CO# 002

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 licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #046 so that their transfer assessments was integrated, consistent with and complemented each other.

On an identified date a Critical Incident Report (CIR) was submitted to the Director, regarding an incident that caused an injury to resident #046 for which the resident was sent to the hospital and resulted in a significant change in health status.

A review of resident #046's health care record (progress notes) indicated that on an identified date, PSW #145 reported to RPN #135 that resident #046 was lowered to the floor in the tub room. Further, it indicated that the resident was standing with two staff at a transfer rail in the tub room. When the resident was unable to tolerate standing, staff were not able to transfer resident to the wheelchair, therefore the resident was lowered to the floor.

Inspector #573 reviewed resident #046's recent MDS assessment dated on an

identified date, which identified that the resident required two person extensive assistance for transfers and for the mode of transfers, it indicated the resident was lifted mechanically. The Nursing Fall Resident Assessment Protocol (RAP)

described that resident #046's last documented fall was on an identified date in 2017, when the resident had to be assisted (lowered) to the floor while transferring in tub room. Further, it indicated that mechanical lift is used for all transfers.

On June 21, 2018, Inspector #573 reviewed the written plan of care in place at the time of the incident for resident #046's transfers. For transfers, the written plan of care indicated that resident #046 required two staff for transfers and mechanical lift to be used when resident was in increased fatigue.

On June 21, 2018, Inspector #573 spoke with Rehabilitation Assistant #146 (Restorative Care) who indicated that they completed the transfer assessment for all the residents in the home. Rehabilitation Assistant #146 indicated that resident's transfer assessment is completed upon initial admission, quarterly, post fall and also when there is significant change in resident's health status. Further, the Rehabilitation Assistant indicated that according to their transfer assessment, resident #046 required two staff side by side transfers and mechanical lift to be used by the staff when the resident was in increased fatigue.

On June 21, 2018, Inspector #573 spoke with RCC #124 who agreed with Inspector #573 that resident #046's transfer assessment was not integrated and updated in the written plan of care to reflect the resident's transfer needs and status.

As such the registered nursing staff and restorative care staff did not collaborate in assessing resident #046's transfer needs, so that their transfer assessments was integrated, consistent with and complemented each other. (Log #006619-18) [s. 6. (4) (a)]

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 staff and others involved in the different aspects of care collaborated with each other in the assessment of resident so that their transfer assessments was integrated, consistent with and complemented each other, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways are i. kept closed and locked, ii.equipped with a door access control system that is kept on at all times, and iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and, A. is connected to the resident-staff communication and response system, or B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a

manual reset switch at each door.

On June 22, 2018, Inspector #573 toured the home with the home's Environmental Services Supervisor (ESS) and Director of Care (DOC). In the main floor, it was observed that the hallway from the Henry Murdoch North (HM1N) residents unit to the home's centre core area consists of an open stairway to the second level. It was observed that from the HM1N unit, the hallway leading to the home's centre core consists of two double doors that were kept open. The ESS indicated to the inspector that those double doors are fire doors/ separations which had a magnetic lock and will release upon fire alarm and on other emergency situation. The ESS stated to the inspector that on the south side of the home near the Henry Murdoch South (HM1S) residents unit, there are two double fire doors/ separations identical/ similar to the doors on the north side.

On the second level Henry Murdoch North (HM2N) residents unit, it was observed that there was a double door that was kept closed but not locked. The ESS indicated that the double doors at the second level are fire doors. From the Henry Murdoch North (HM2N) unit hallway, upon opening the double door, to the left is open stairways leading to the main level. Further down the hallway is the supervised residential area which includes hair salon, laundry and craft room. At the second level stairway, there are two posts that block the stairway which would limit access from going down the stairs using a wheelchair, but nothing preventing someone from walking down the stairs. The ESS stated to the inspector that on the second level at the south side of the home near the Henry Murdoch South (HM2S) residents unit, there are double doors identical/ similar to the doors on the north side which was kept closed, but not locked.

On June 22, 2018, Inspector #573 discussed with ESS in order to assess the above observed fire doors and its security. It was determined that none of the above observed doors that lead to stairways, were equipped with a door access control system and alarm as prescribed by O. Reg. 79/10, s. 9 (1) ii. iii.

The home's DOC and ESS agreed with Inspector #573 that the open stairways in the home are a risk for potential harm to the residents. The DOC indicated to the inspector that the stairway concerns will be discussed with the management and measures will be taken to address those identified concerns. [s. 9. (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 doors leading to stairways are i. kept closed and locked, ii.equipped with a door access control system that is kept on at all times, and iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and, A. is connected to the resident-staff communication and response system, or B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

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

Critical Incident Report (CIR) which was submitted by the licensee to the Ministry of Health and Long-Term Care on an identified date indicated that on a specified date, PSW #125 and PSW #130 observed PSW #127 providing care to multiple residents in a rough manner. This rough care included roughly manipulating residents' extremities when dressing and undressing the residents, pulling the sling out from under one resident in a rough manner, and quickly pulling some residents

along the ceiling lift track by pulling the resident by the sling, rather than using the lift's remote control. The CIR also indicated that PSW #125 and PSW #130 observed PSW #127 using profanity in front of multiple residents.

During an interview with Inspector #178 on June 15, 2018, PSW #130 indicated that on a specified date, PSW #130 witnessed that PSW #127 was rough while assisting several residents to dress or undress during care. PSW #130 indicated that they witnessed PSW #127 do the following:
- roughly pushed resident #049's forward and back in the wheelchair in order to straighten the resident's clothing and roughly removed the lift sling from under the resident. PSW #127 also cursed in front of, but not at resident #049, and quickly pushed resident #049 along the ceiling lift track while the resident was in the lift sling, rather than use the lift remote control, as per usual practice.
- threw resident #050's blanket at the resident, hitting the resident. PSW #130 indicated that resident #050 was not injured, but afterward resident #050 asked PSW #127 "why are you always mean to me".
- roughly undressed resident #051. The resident frowned in response.
- roughly removed the lift sling from under resident #052, roughly grazing the resident's specific body part in the process. When this happened, resident #052 grabbed their body part and expressed that it hurt.
- roughly undressed resident #055. Resident #055, who does not speak, made noises during this process, which PSW #130 felt indicated the resident was experiencing discomfort. PSW #127 also pushed resident #055 along the ceiling lift track while the resident was in the lift sling, rather than using the mechanical lift remote control, as per usual practice.
- roughly undressed resident #053 and cursed in front of, but not at the resident. Afterward, resident #053 indicated to PSW #130 that they do not want PSW #127 in their room because PSW #127 is rough.

PSW #130 indicated to Inspector #178 that they considered PSW #127's treatment of residents #049, #050, #051, #052, #053 and #055, to be physically abusive. PSW #130 indicated that when PSW #127 went to break, they reported the physical abuse and cursing to RPN #132 and RN #131, and the registered staff ensured that PSW #127 was sent home. PSW #130 indicated awareness that the home's abuse prevention policy requires staff to immediately report suspected abuse to their supervisor. PSW #130 further indicated that as a result of not immediately reporting the abuse when first observed, PSW #130 failed to follow the home's abuse prevention policy.

Inspector #178 reviewed the licensee's policy titled Prevention of Abuse or Neglect, policy #G-006, dated October 1995, Revision Date January 22, 2018. The policy included a definition of physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain. The policy further indicated that for the purposes of the definition of physical abuse, physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances. The policy indicated that anyone who witnesses any form of abuse/neglect/inappropriate care, or is aware of alleged or suspected abuse/neglect/inappropriate care is responsible for reporting it to their supervisor or designate immediately. The policy further indicated that when abuse or inappropriate care is suspected, the following four steps should be followed:
A) Intervene
B) Report; and
C) Investigate
D) Document objective facts.

During an interview with Inspector #178 on June 19, 2018, RCC #124 indicated that PSW **#**130 did not follow the home's policy to promote zero tolerance of abuse in this case because PSW #130 did not immediately report their suspicion of abuse after witnessing the first incident of rough care with the first resident. (Log #005082 -18) [s. 20. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On June 21, 2018, at approximately 1115 hours, Inspector #142 observed Maintenance staff #144 unlock and enter the medication room located at the nursing station on the main floor Henry Murdoch (HM1). When Inspector #142 asked Maintenance staff #144 if they had a key to the medication room, they indicated that they do not have keys to the medication rooms and that RPN #143 provided them with the key. After Maintenance staff #144 entered the medication room, RN #141 entered the medication room. RN #141 indicated to Inspector#142 that supplies were required and staff member #144 needed to deliver them to the medication room. Inspector #142 observed the medication room and noted an unlocked cupboard with resident medication, an unlocked treatment cart with prescription creams and an unlocked medication cart.

In an interview with RPN #143, they indicated that keys to the medication room were provided to Maintenance staff #144 to deliver supplies. RPN #143 further indicated that the keys provided to Maintenance staff #144 included keys to the narcotic box. RPN #143 confirmed that the medication cart was not locked and further acknowledged that keys should not have been provided to the maintenance staff member. [s. 130. 2.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Resident #056 had multiple diagnoses. Resident # 056 had a physician order for an identified medication patch with a specified dosage. On an identified date, when registered nursing staff went to apply a new patch, registered nursing staff discovered that resident #056 had a medication patch with a dosage that was not as ordered by the physician. The above noted resident health care record was reviewed and there was no evidence of any adverse effects to the resident as a result of the medication incident. [s. 131. (2)]

Issued on this 10 day of September 2018 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de 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

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by ANANDRAJ NATARAJAN (573) - (A1)

Inspection No. / No de l'inspection : 2018_593573_0010 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 010776-18 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Sep 10, 2018;(A1)

Licensee / Titulaire de permis : The Corporation of the County of Renfrew
9 International Drive, PEMBROKE, ON, K8A-6W5

LTC Home / Foyer de SLD : Bonnechere Manor
470 Albert Street, RENFREW, ON, K7V-4L5

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Shelley Sheedy

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

To The Corporation of the County of Renfrew, you are hereby required to comply with the following order(s) by the date(s) set out below:

(A1)
The following Order has been rescinded:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

(A1)
The following Order has been rescinded:

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 10 day of September 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by ANANDRAJ NATARAJAN - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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Service Area Office / Bureau régional de services : Ottawa