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 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 25, 2019	2019_770178_0012	002596-19	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

Bonnechere Manor
470 Albert Street RENFREW ON K7V 4L5

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): June 25, 26, 27, 28, July 2, 2019 onsite-July 10, 2019 offsite.

Log #002596-19, regarding a choking incident, was inspected.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RNs), a Registered Practical Nurse (RPN), Personal Support Workers (PSWs), the Registered Dietitian (RD), the Food Service Supervisor, Food Service Workers (FSWs), residents.

During the course of the inspection, the inspector also conducted dining observations, reviewed resident health records including plans of care, nutrition assessments, and progress notes, reviewed licensee policies, training records, and documentation of the licensee's investigation into the incident.

The following Inspection Protocols were used during this inspection:
Dining Observation
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **2 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	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, on two identified dates.

This non-compliance is related to Log #002596-19 and Critical Incident Report (CIR) #M506-000002-19.

CIR #M506-000002-19, which was submitted by the licensee to the Ministry of Health and Long-Term Care, indicated that on an identified date, resident #001 was provided with a full chicken nugget when their plan of care indicated they should receive minced meat. Resident #001 attempted to eat the full chicken nugget and experienced a choking episode which was relieved after the Heimlich Maneuver and oral suctioning was performed to remove the chicken nugget. Resident #001 sustained bruising and soreness as a result and was provided with medication for the pain. The resident had no further adverse effects and returned to their usual condition.

Inspector #178 reviewed resident #001's plan of care for nutrition which was in place at the time of the choking incident. The plan of care indicated that resident #001 should receive a regular diet with a modified texture of minced meat.

Food Service Worker (FSW) #101 indicated to Inspector #178 that on an identified date, they provided a meal of full-sized chicken nuggets for resident #001. FSW #101 filled the plate for a Personal Support Worker (PSW), who then served the meal to resident #001. FSW #101 indicated that resident #001 should have received minced meat texture, rather than the whole nuggets. FSW #101 indicated that they did not check the diet list as they were supposed to, so they did not realize that resident #001 had been changed to a minced meat texture.

PSW #111 indicated to Inspector #178 that on an identified date, they served a meal of full sized chicken nuggets to resident #001 when the resident should have received a minced meat diet. PSW #111 indicated that they provided the FSW with resident #001's first name and menu choice, but may not have provided the resident's last name. PSW #111 further indicated that they did not provide the FSW with information about resident #001's required diet and texture.

Registered Practical Nurse (RPN) #110 indicated to Inspector #178 that on an identified date, resident #001 was incorrectly served whole chicken nuggets when the resident should have received minced meat. As a result, resident #001 choked on a chicken nugget and after several attempts, RN #109 was able to remove the obstruction by performing the Heimlich Maneuver.

Approximately five months later, Inspector #178 observed during the lunch meal that resident #001 was served a chicken drumstick. The meat was then cut off the bone by PSW #104, and then cut into smaller pieces by PSW #103. Resident #001 consumed some of the chicken meat with the assistance of PSW #103. Resident #001 did not experience any coughing or choking during the meal. Inspector #178 reviewed resident #001's plan of care which indicated that resident #001 required a regular diet with Soft Minced Meat texture. Review of the Soft Minced Meat menu posted in the dining room for the lunch meal indicated that resident #001 should have received minced chicken for the meal. FSW #106, who plated the lunch meal, (placed the food on plates for the PSWs to serve to the residents), indicated to Inspector #178 that a resident on the Soft Minced Meat diet could receive soft meats, as long as they are cut up by the PSW who serves the resident. FSW #106 indicated that if the meat on a chicken leg is soft enough, the PSWs can break it off the bone and serve it to resident #001, who is ordered a soft minced meat texture.

Inspector #178 interviewed FSW #101 on June 26, 2019. FSW #101 indicated that the Soft Minced Meat texture is a new concept and they are not certain what to provide for residents who require the Soft Minced Meat texture. FSW #101 indicated they believe that if the regular texture meat was tender and could be broken apart with a fork, then it could be served to residents ordered a Soft Minced Meat texture.

The Food Service Supervisor (FSS) informed Inspector #178 on June 26, 2019, that the Soft Minced Meat texture has been in use since May 20, 2019. The FSS indicated that for the Soft Minced Meat texture, all meats other than fish are to be served minced, and the FSW staff should be checking the menu or the Temperature/Food Waste Record form to determine what texture of meat to serve for a resident ordered the Soft Minced Meat texture. The FSS indicated that on the day that Inspector #178 observed resident #001 receive the chicken drumstick at lunchtime, resident #001 should have received minced chicken, which was mechanically minced in the kitchen. The FSS indicated that FSWs received instruction regarding the new Soft Minced Meat texture at a menu meeting on May 17, 2019, but that only staff who were working that day would have attended. The FSS indicated that the remainder of FSWs were expected to read the notes regarding use of the new Soft Minced Meat texture in the dietary communication binder, which all food service staff are expected to check before beginning their shift.

The DOC indicated to Inspector #178 that it is expected that PSW staff will provide the FSW who is plating the meal with the resident's full name, their diet and their menu choice for that meal, and the PSW will notify the FSW if they have provided the wrong

diet for a resident.

In conclusion, on two identified dates, resident #001 was not provided with their required meal texture as per their plan of care. [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 resident #001 as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
This non-compliance is related to Log #002596-19 and Critical Incident Report (CIR) #M506-000002-19.

CIR #M506-000002-19, which was submitted by the licensee to the Ministry of Health and Long-Term Care indicated that on an identified date eighteen days previous, resident #001 was provided with a full chicken nugget when their plan of care indicated they should receive minced meat. Resident #001 attempted to eat the full chicken nugget and experienced a choking episode which was relieved after the Heimlich maneuver and oral suctioning was performed to remove the chicken nugget. Resident #001 sustained bruising and soreness as a result, and was provided with medication for the pain.

Registered Nurse (RN) #113 was the RN in charge when resident #001 choked on a chicken nugget. RN #113 indicated that they and RN #109 began the investigation into why the resident choked, as soon as the obstruction was relieved and the resident was stable. RN #113 indicated that they determined on the day the resident choked that resident #001 was provided with the wrong texture of meat, and subsequently choked on a whole chicken nugget. RN #113 could not remember if the Director under the Long-Term Care Homes Act was immediately informed of the incident, as per the requirements.

The Director of Care (DOC) indicated to inspector #178 that the choking incident was reported to the Director under the Long-Term Care Homes Act late, eighteen days after the incident occurred. The DOC indicated that this was an oversight, as staff were concentrating on investigating how the incident occurred, in order to prevent recurrence. [s. 24. (1) 1.]

Issued on this 7th day of August, 2019

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

Original report signed by the inspector.