Ontario

**Inspection Report Under the**
**Fixing Long-Term Care Act, 2021**

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

**Ottawa District**
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

# Original Public Report

| | |
|---|---|
| **Report Issue Date:** January 26, 2024 | |
| **Inspection Number:** 2024-1532-0001 | |
| **Inspection Type:**<br>Complaint<br>Critical Incident | |
| **Licensee:** The Corporation of the County of Renfrew | |
| **Long Term Care Home and City:** Bonnechere Manor, Renfrew | |
| **Lead Inspector**<br>Karen Buness (720483) | **Inspector Digital Signature**<br>Karen Lynne Buness<br>Digitally signed by Karen Lynne Buness<br>Date: 2024.01.30 10:37:54 -05'00' |
| **Additional Inspector(s)**<br>Shevon Thompson (000731) | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 9, 10, 11, 12, 15, 16, 17, 2024

The following intake(s) were inspected:
• Intake: #00098684 - Fall of a resident which resulted in a significant change in health status
• Intake: #00102236 - Resident to resident verbal and physical abuse
• Intake: #00102487 - Complaint related to resident care and services and prevention of abuse
• Intake: #00102495 - Alleged staff to resident emotional abuse

- Intake: #00104542 - Controlled substance missing/unaccounted for
- Intake: #00101556 - Controlled Substance missing/unaccounted for

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 28 (1) 2.**
Reporting certain matters to Director
s. 28 (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:
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.

The licensee has failed to immediately report 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.

On a specific date, the licensee submitted a critical incident to report an incident of

resident to resident abuse involving three residents. As per the report and confirmed by a Resident Care Coordinator, none of the residents involved were injured or expressed concerns immediately after the incident therefore the incident was not reported. The licensee reported the incident three days later after one of the residents involved expressed concern of their safety and fear of one of the residents as a result of the incident.
A review of the documentation revealed the day after the incident, the third resident involved reported a sore left hand from being grabbed by one of the residents during the incident. The resident was assessed by registered staff and provided an analgesic for pain.

As per FLTCA s. 28 (1) 2. the licensee is required to immediately report 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.

Failure to report the incident immediately could have impacted the licensee's investigation and response to the incident.

Sources: Resident health records, interview with a RCC

[720483]

## WRITTEN NOTIFICATION: Infection Prevention and Control

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)**
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection

prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control (IPAC), specifically related to the use of hand hygiene as is required by Additional Requirement 9.1 under the IPAC Standard.

On a specific date and time inspector #720483 observed a Registered Practical Nurse (RPN) administer medications to five residents. The RPN failed to perform hand hygiene after administering medications to a resident and before administering medications to a new resident on all five occasions. When interviewing the RPN, they acknowledged they did not perform hand hygiene during the observed medication administration stating it was their understanding hand hygiene after administering medication to residents who do not require physical assistance is not required.

Infection Prevention and Control (IPAC) lead #107 stated staff must follow the four moments of hand hygiene during medication administration, including before and after administering medications to each resident.

Lack of hand hygiene increases the risk of disease transmission among residents and staff.

Sources: Observations made by the inspector and interviews with the IPAC lead an a RPN

[720483]

## WRITTEN NOTIFICATION: Safe storage of drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)**
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that drugs stored in an area or a medication cart is secure and locked.

On a specific date, inspector #720483 walked through a unit nursing station to the medication room which is located at the at the back of the nursing station. Inspector found the medication room door open. A registered staff member was sitting in the nursing station but behind a partial partition and did not appear to notice inspector enter the medication room. Upon entry the inspector observed two medication carts and found them both unlocked and was able to open the drawers of the medication carts.
On the same day inspector entered a second unit nursing station and similarly found the medication room and two medication carts open. A registered staff member was in the nursing station with their back to the room. Again, inspector was able to enter the room and open the drawers of the medication carts without being noticed.

Inspector interviewed one Registered Nurse (RN) and three Registered Practical Nurses (RPN) and all four registered staff members stated the medication room door was left open as long as there is a registered nurse in the nursing station but if there is no registered staff present it is closed and locked. Two RPN's stated they did not lock the medication cart when the cart is inside the medication room.

Both the Director of Care (DOC) and a Resident Care Coordinator stated the medication room is left open if registered staff are in the nursing station but the medication room and medication cart should be locked if not visible to the registered staff.

The licensee's Manual for Medisystem Serviced Home, Policy and Procedures Section E-Medication Handling directs staff to keep medication the cart locked at all times when not directly under the supervision of staff administering the medications. Section F- Specialty Handling states narcotic and controlled substances must be stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Failure to ensure that medication is secure and locked puts the residents at risk and the licensee at an increased risk of medication incidents.

Source: Observations by the inspector, Manual for Medisystem Serviced Home, Policy and Procedures Section E pg. 43 and Section F pg. 55, December 2023, interviews with registered staff, RCC #100 and DOC #115

[720483]