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

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Original Public Report

Report Issue Date: January 9, 2024	
Inspection Number: 2023-1532-0005	
Inspection Type: Proactive Compliance Inspection	
Licensee: The Corporation of the County of Renfrew	
Long Term Care Home and City: Bonnechere Manor, Renfrew	
Lead Inspector Karen Buness (720483)	**Inspector Digital Signature** Karen Lynne Buness Digitally signed by Karen Lynne Buness Date: 2024.02.07 14:56:03 -05'00'
Additional Inspector(s) Gurpreet Gill (705004)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 22, 23, 24, 27, 28, 29, 30, 2023 and December 1, 4, 5, 6, 2023

The following intake(s) were inspected:

- Intake: #00102055 - PCI

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Residents' and Family Councils

Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the

current version of the visitor policy made under section 267.

Non-Compliance was found during this inspection and was remedied by the Licensee prior to the conclusion of the inspection. The Inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

Rationale and Summary

During the inspection it was noted that the most current version of the Licensee's visitor policy was not posted in the home. In an interview with the Administrative Assistant they stated that the most current version of the visitor policy is emailed to families and essential care givers and is also available on the County of Renfrew website for general visitors. The Administrative Assistant acknowledged that the visitor policy was not posted in the home.

Shortly after the interview the most current version of the visitor policy was posted in the home.

The impact of the policy not being posted in the home was low because it was made available by email and online.

Sources: Observations, interview with Administrative Assistant and Resident Visiting Policy #G.026

Date Remedy Implemented: November 22, 2023

[720483]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
Documentation
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the food and fluid intake of residents with identified risks related to nutrition and hydration was documented.

Rationale and Summary

Three residents were assessed as being at nutritional risk, as per their plan of care.

A review of the nourishment and fluid intake documentation for the first resident showed that in one specific month there were three days, where the resident's AM nourishment was not documented, and four days where fluid intake was not documented.

A review of the documentation for the second resident showed that in the same month there was one day where the resident's fluid intake was not documented.

The third resident's documentation showed that in the same month, there was one day where the resident's AM nourishment and fluid intake were not documented.

During an interview, the Director of Care (DOC) indicated that the three residents received their nourishments and fluids, but the staff did not complete their

documentation. The DOC indicated that staff were expected to document every shift.

As such residents' food and fluid intake were not documented who were identified at high nutritional risk, may pose a potential risk of harm in the evaluation of residents' nutrition and hydration monitoring.

Sources: Residents health care records and interview with the DOC.

[705004]

WRITTEN NOTIFICATION: Communication and response system

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20 (a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

Rationale and Summary

On a specific date following an interaction with inspector #705004, the resident asked the inspector to to find their call bell for them explaining that they were unable to reach it and they required assistance from the staff. Inspector #705004 located the call bell on the resident's right side but to access the call bell the

inspector had to pull a cord due to it being stuck underneath the resident.

On another occasion, inspector #720483 observed a resident sitting in a wheelchair in their room in front of the television. The resident's call bell was noted to be attached to the side rails of the bed, not within their reach. On the same day inspector observed an additional resident asleep in their tilt wheelchair which was positioned in the middle of the room with the call bell attached to the bed's side rail similarly, not within reach of the resident. A review of both residents' activity of daily living (ADL) assessments revealed both residents require physical assistance from two or more staff to move from one area of the room to another.

The following day inspector #720483 observed another resident laying in bed asleep, the call bell was observed to be laying on the floor under the bed. The resident's ADL assessment indicates the resident requires physical assistance from two or more staff to move and change position while in bed.
During an interview with a Personal Support Worker (PSW), they confirmed staff are to ensure residents have their call bell within reach.

Failure to ensure residents have access to their call bells puts the resident at an increased risk of injury and not having their personal needs met.

Sources: Resident health records, observations and interview with a PSW.

[720483]

WRITTEN NOTIFICATION: Accommodation Services

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

The licensee has failed to comply with written policies related to accommodation services.
In accordance with O. Reg 246/22 s.11 (1) (b) the licensee is required to have policies as part of accommodation services and that they are complied with.

Rationale and Summary

During an interview a Personal Support Worker (PSW) stated the procedure when cleaning shared resident equipment is to clean the equipment before using it to assist a resident. A second PSW reported shared resident equipment is cleaned after use. A third PSW stated they believed the policy directed staff to clean resident shared equipment after use, but it was their practice to clean the equipment both before and after using it to assist a resident.

A review of the Cleaning of Resident/Staff Shared Equipment Policy revealed staff

are directed to clean equipment after each resident use.
The Infection Prevention and Control (IPAC) Lead stated the front line staff receive training on the cleaning of resident and staff shared equipment and confirmed it is the expectation that staff clean shared equipment after use.

Failure to consistently follow the cleaning of resident shared equipment policy puts residents at an increased risk of communicable infections.

Sources: Cleaning of Resident/Staff Shared Equipment Policy, interviews with IPAC Lead and Personal Support Workers.

[720483]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 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).

Non-compliance with O. Reg. 246/22 s. 102 (2)(b), IPAC Standard section 9.1

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 personal protective equipment (PPE) and hand hygiene as is required by Additional Requirement 9.1 under the IPAC Standard.

A) Rationale and Summary

On a specific date, inspector #705004 observed that a resident had personal protective equipment (PPE) supplies at the room entrance and contact precaution signage posted at the entrance to the resident's room or bed space indicating that enhanced IPAC measures were in place for this resident.

The inspector observed two Personal Support Workers (PSW) exit the resident's room, who required contact precautions. The first PSW was not wearing a gown when they exited the room and carried laundry. The second PSW was inside the room and was observed not wearing the appropriate PPE (gown).

During an interview with the second PSW, they indicated that the resident is on contact precautions and acknowledged that they were not wearing a gown. Furthermore, the PSW indicated that they should wear a gown when they were providing direct care to the resident.

Failing to participate in the implementation of the IPAC program increases the risk of disease transmission among residents and staff when the resident is required to be on additional precautions.

Sources: Observations made by the inspector and interview with a PSW.

[705004]

B) Rationale and Summary

On a specific date, inspector #705004 observed that a Personal Support Worker

(PSW) assisted a resident to sit in the dining chair in the the unit dining room. The PSW then moved the resident's walker to the side and applied a clothes protector to the resident. Subsequently, the PSW applied a clothes protector to another resident who was in a wheelchair. The PSW then moved the resident's walker into the hallways near the window and then proceeded to another resident who was sitting near the wall in the dining room and applied a clothes protector apron. Afterward, the PSW adjusted another resident's hearing aid, removing and putting it back. The PSW did not perform hand hygiene before and after applying clothes protectors to different residents, and before and after touching residents, their walker, and before and after adjusting the resident's hearing aid.

On a different date, a PSW was observed with their mask improperly applied (the mask was down the nose) in the unit dining room. The PSW took a container with wrapped cutlery in paper napkins to distribute and set on tables. It was brought to the PSW's attention and the PSW adjusted their mask and, with the same hand, picked up cutlery from the container for distribution. The PSW did not perform hand hygiene after adjusting their mask and before picking up the cutlery from the container.

During another observation, the inspector #705004 observed that a PSW brought a resident in a wheelchair into the unit dining room, the PSW moved multiple resident wheelchairs to position the resident's wheelchair near the table. PSW then proceeded to an additional resident and adjusted their clothes protector. The PSW did not perform hand hygiene before and after touching the residents' wheelchairs and before and after adjusting the resident's clothes protector.

During an interview with the PSW observed they confirmed that they forgot to sanitize their hands and acknowledged that they are supposed to sanitize their hands between residents.

The Infection Prevention and Control (IPAC) lead indicated staff must follow the four moments of hand hygiene: before and after contact with the resident or resident's environment, and in between residents.

As such, a 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 and Personal Support Workers

[705004]