**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
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**Public Copy/Copie du public**

| Date(s) of inspection/Date(s) de l'inspection Jan 19 2012 LD | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| Jan 12, 13, 18, 23, 24, 2012 | 2012_034117_0004 | Critical Incident |

**Licensee/Titulaire de permis**

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**

LYNE DUCHESNE (117)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Resident Care Coordinator, to several Registered Nurses (RNs), to several Registered Practical Nurses (RPNs), to several Personal Support Workers (PSWs), to a housekeeper, to the home's Environmental Services Manager and to several residents.**

**During the course of the inspection, the inspector(s) reviewed the health care records of four identified residents; examined a resident care unit tub room and examined the tub room door locking mechanism; reviewed the Bonnechère Manor Management Team Meeting Minutes November 2011; reviewed a Bonnechère Manor Resident Care Unit Team Meeting Minutes December 2011; reviewed an internal Employer Investigation Report 2011; and reviewed three critical incident reports.**

**It is noted that three critical incident inspections, Log # O-001510-11, Log # O-001727-11 and Log # O-002577-11, were conducted during this inspection.**

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

**Dignity, Choice and Privacy**

**Falls Prevention**

**Hospitalization and Death**

Responsive Behaviours

Safe and Secure Home

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON-RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 3. Residents' Bill of Rights**

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

**22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.**
**23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.**
**24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.**
**25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.**
**26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.**
**27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).**

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**Findings/Faits saillants :**

1. The following instances show the licensee failed to comply with section 3 (1) (4) of the LTCHA 2007, in that an identified resident was not properly cared for in a manner consistent with his/her care needs.

In early July 2011, the identified resident had been unwell: decreased food and fluid intake, expressed dizziness and was suspected of having had an episode of emesis. The resident is cognitively impaired and is known to have cardiac problems. The resident was seen by his physician on a specified day in July 2011.

On a specified day in July 2011, the identified indicated that he/she was having chest pains. The resident was assessed by an RN #1. The physician was contacted and a request was made to transfer the resident to hospital for further assessment.

On the specified day in July 2011, another RN #2 made arrangements to have the resident sent to hospital. RN #2 called the regional handicap transit service and placed the resident on the transit service bus to the hospital. The resident was sent to hospital unaccompanied and with no medical/nursing supervision.

The home's director of care, resident care coordinator and unit RN stated during interviews that the home's process is to contact 911 emergency services to transfer to hospital residents presenting with acute changes in their health status for further assessment. [Log # O-001510-11]

***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 residents are properly cared for in a manner consistent with their needs when being transferred to hospital for further assessments and treatments, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.**

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**Findings/Faits saillants :**

1. In the afternoon of a specific day in November 2011, an identified resident entered a resident care unit tub room.

At approximately 15:45 pm a PSW noted that water was flowing out from under the tub room door. The tub room door was locked. When the PSW opened the tub room door, the identified resident was found to be standing in the tub. A large laceration was noted to be present at the back of his/her head. Water was spraying in and out of the tub.

The resident was assessed, removed from the tub room and transferred to hospital for further assessment and treatment. The resident, who is cognitively impaired, was unable to explain how he/she accessed the tub room.

Interviewed RN, RPN, PSWs, housekeeper and Environmental Services Manager state that at the time of the incident, the resident care unit tub room doors had locks that opened and locked with a key. At the time of the inspection it was noted that the home had changed all tub room door locks to automatic locking door mechanisms. [Log # O-002577-11]

**Issued on this 24th day of January, 2012**

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