Ontario

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
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 26, 27, 28, 2012	2012_044161_0027	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

KATHLEEN SMID (161)

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, Director of Care, Environmental Services Manager, RAI Coordinator and Resident Care Coordinator.

During the course of the inspection, the inspector(s) observed the door/locking mechanism which opens to an inner courtyard, reviewed resident # 001's health record, Renfrew County and District Health Unit Home Outbreak Notifications dated April 26, 2012 and May 22, 2012, Employer Investigation Report from January 2012.

During the course of the inspection, three Critical Incident inspections were also conducted: # M506-000006-12, M506-000027-12, M506-000033-12.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control

Responsive Behaviours

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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. 9. Doors in a home

Specifically failed to comply with the following subsections:

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.
1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents.
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. (1).

Findings/Faits saillants :

The Licensee failed to comply with O. Reg 79/10 r. 9. (1)(1)(i) in that a door leading to the outside of the home was not locked.

During a night shift in January 2012, a Registered Nurse unlocked the door to the inner courtyard on a resident care unit in order to go outside and smoke. Afterward, the Registered Nurse entered back into the home from the inner courtyard and failed to lock the door.

During an evening shift three days later in January 2012 Resident # 001 wandered through the unlocked door into the courtyard on the resident care unit. The nursing staff on the resident care unit noted that Resident # 001 was missing. They immediately initiated a search for missing Resident # 001. He/She was found lying in the snow in the courtyard of the resident care unit. He/She did not suffer any ill effects. [log # O-000184-12]

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 the outside of the home are locked, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding.
2. An unexpected or sudden death, including a death resulting from an accident or suicide.
3. A resident who is missing for three hours or more.
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

The Licensee failed to comply with O. Reg 79/10 r. 107 (1) (5) in that the Director was not immediately informed of an outbreak of a reportable disease as defined in the Health Protection and Promotion Act.

On April 26, 2012 the Renfrew County and District Public Health Unit declared a respiratory outbreak in the home.

On April 27, 2012 the Director was notified of the respiratory outbreak by the Critical Incident System. [Log # O-001043-12]

On May 22, 2012 the Renfrew County and District Public Health Unit declared a respiratory outbreak in the home.

On June 1, 2012 the Director was notified of the respiratory outbreak by the Critical Incident System. [Log # O-001355-12]

Issued on this 28th day of June, 2012

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

Kathleen Smid