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 sous la Loi de 2007 sur les foyers de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 6, 2014	2014_199161_0010	O-000269-14	Resident Quality Inspection

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), ANGELE ALBERT-RITCHIE (545), MEGAN MACPHAIL (551), RUZICA SUBOTIC-HOWELL (548)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): April 24, 25, 28, 29, 30, 2014, May 1, 2, 2014.

During the course of the inspection, the inspector(s) spoke with Residents, Family Members,Volunteers, a member of Residents' Council, Chair of Family Council, Personal Support Workers (PSW), Registered Nurses (RN), Registered Practical Nurses (RPN), a Dietary Aide, Housekeeping Aide, Environmental Service Supervisor, Pharmacist, Dietitian, Food Service Supervisor, Administration Supervisor, Resident Care Coordinators, RAI MDS Coordinator, Director of Care and the Administrator.

During the course of the inspection, the inspector(s) conducted a tour of the Resident care areas, reviewed Residents' health care records, home policies and procedures, staff work routines, posted menus, observed Resident rooms, observed Resident common areas, reviewed the Admission process and Quality Improvement system, reviewed Residents' Council and Family Council minutes, observed a medication pass, observed one meal service, and observed the delivery of Resident care and services.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure compliance with LTCHA 2007, c. 8, s. 6 (10) (b) in

that the licensee did not ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary.

On April 29, 2014, the Registered Dietitian (RD) was interviewed. The RD stated that all documentation related to weight changes is in the progress notes, and that residents' weights are assessed on a quarterly basis with the Minimum Data Set (MDS). When asked by Inspector #551 if residents' weights were assessed monthly, the RD stated "no".

Resident #3639's weight history was reviewed. It showed that Resident #3639's body weight declined 5.4% (2.9kg) over a one month period in 2014. The progress notes were reviewed, and there is no entry by any discipline addressing the weight loss of 5.4% (2.9kg) over a one month period. According to the progress notes, Resident #3639's weight was last assessed on a specified date in January 2014 in a "Nutrition Quarterly Review and MDS Assessment" completed by the Assistant Food Service Supervisor. At the time of the inspection, the resident had not been reassessed, and the weight loss had not been addressed as per the Home's process of assessing weight changes on a quarterly basis only.

Resident #0014's weight history was reviewed. It showed that Resident #0014's body weight declined 6.3% (3.4kg) over a one month period in 2014. The progress notes were reviewed, and there is no entry by any discipline addressing the weight loss of 6.3% (3.4kg) over a one month period. At the time of the inspection, the resident had not been reassessed, and the weight loss had not been addressed as per the Home's process of assessing weight changes on a quarterly basis only.

Resident #0013's weight history was reviewed. It showed that Resident #0013's body weight declined 5.6% (2.5kg) over a one month period in 2013. The weight loss of 5.6% (2.5kg) was assessed forty one days later on a specified date in January 2014 when the Assistant Food Service Supervisor completed a "Nutrition Quarterly Review and MDS Assessment". The assessment stated "Have informed RD of poor fluid intake and weight loss, RD to f/u". Resident #0013's weight continued to decline, and Resident #0013 was assessed seventy seven days later on a specified date in April 2014 by the RD.

In summary, Resident #3639 and Resident #0014 experienced significant weight losses over a one month period in 2014, and at the time of the inspection their care

needs had not been reassessed. Resident #0013 experienced significant weight loss over a one month period in 2013 the Resident's care needs were assessed by the RD one hundred and eighteen days later on a specified date in April 2014. [s. 6. (10) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 r.17 (1) (a) in that the licensee did not ensure that the home is equipped with a resident-staff communication and response system that can be easily used by residents, staff and visitors at all times.

The home is equipped with an Austco resident-staff communication and response system that clearly indicates when activated, where the signal is coming from. Residents activate this communication system by pulling on a call bell cord located in their room and in their bathroom.

On April 25 and 29, 2014 Inspector #161 conducted a random audit of 12 Resident bathrooms and observed that all the call bell cords in the 12 Resident bathrooms were wrapped several times around the toilet's support arm. When the inspector pulled on the call bell cord, the resident-staff communication response system was not activated. When Inspector #161 un-wrapped the call bell cords from the toilet's support arm and pulled the call bell cord, the system was activated. On April 30, 2014 Inspector #161 asked the home's Director of Care to accompany her to a specified Resident's room. They observed that the call bell cord was wrapped around the toilet's support arm. When Inspector #161 pulled on the call bell cord, the resident-staff communication response system was not activated. When Inspector #161 un-wrapped the call bell cord from the toilet's support arm and pulled the call bell cord, the system was activated. Thus, when the call bell cords are wrapped around the toilet's support arm, the resident-staff communication system is rendered unusable. The Director of Care indicated that she would immediately address this issue. [s. 17. (1) (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

s. 87. (2.1) The licensee shall ensure that the staff member designated under subsection 229 (3) to co-ordinate the infection prevention and control program is involved in selecting the disinfectant referred to in clause (2) (b). O. Reg. 363/11, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s.87 (2) (d) in that the home did not developed and implement procedures on how to address incidents of lingering offensive odours.

Throughout the course of this inspection, lingering offensive odors were observed by inspectors #161, #545, #548 and #551 in all resident home areas including hallways with soiled utility carts , lounge areas and a specified resident room.

On April 29, 2014 Inspector #545 asked the Environmental Services Supervisor (ESS) for the home's policy on how to address lingering offensive odors. He provided Inspector the following standard operating procedures:
1) Bathroom Cleaning SOP# HK-101, revised March 4, 2014
2) Cleaning Bathroom of Isolation Room SOP# HK-117, revised March 4, 2014
3) Isolation Room Cleaning SOP# HK-118, revised March 4, 2014
In reviewing the above three standard operating procedures, the ESS indicated that the home did not have a procedure to address lingering offensive odors.

Housekeeping aides #S107, #S109 and #S122 indicated during interviews that they were aware that lingering offensive odors came from a specified room and that they used Vert-2-Go Bio deodorizer to try to eliminate the odor but were unsuccessful. Staff #S107 added that the lingering offensive odor probably seeped under the floor as she was unable to eliminate it and that it had been a problem for years. Staff S#107, S#109 and S#122 indicated that they did not inform the ESS that they were unable to eliminate the lingering offensive odor coming from the specified room.

During an interview with PSW #S108 on April 29, 2014 she indicated that lingering

offensive odors came from the soiled utility carts that were left on the units all day.

PSW #S118 and RPN #S117 who provide daily care to Resident #3650 in the specified room, indicated during discussion on April 30th, 2014 that they were aware of the lingering offensive odor coming from this room. They indicated that housekeeping staff used a deodorizer that sometime helped decrease the odor that they attributed to Resident's 3650's night catheter bag left in the room during the day.

On April 29, 2014 around 14:30, during a tour of two Resident units, the ESS, confirmed to Inspector #545 that lingering offensive odors were present. He stated that the specified room would get a heavy cleaning before end of day on April 30, 2014. On May 2, 2014 when Inspector #545 observed the specified room, the lingering offensive odor still persisted.

As such the licensee did not ensure that the home developed and implemented procedures for addressing incidents of lingering offensive odours. [s. 87. (2) (d)]

2. The licensee has failed to comply with O.Reg 79/10 s.87 (2.1) 1 in that the licensee did not ensure the Resident Care Coordinator who was the staff member designated to co-ordinate the infection prevention and control program is involved in selecting the low-level disinfectant.

On April 30, 2014 the Resident Care Coordinator/Infection Control Practitioner indicated to Inspector #545 that she has been responsible for the home's Infection Prevention and Control Program for the past three years. She stated that she has never been involved in selecting the low-level disinfectant used in the home. She further indicated that the previous Environmental Services Supervisor (ESS) selected solutions to be used by Housekeeping Department without the involvement of the Infection Control Practitioner. In reviewing the home's Infection Prevention and Control Terms of Reference 2014, the requirement to involve the staff member designated to co-ordinate the infection prevention and control program in selecting the low-level disinfectant was not documented.

As such, the home did not ensure the involvement of the Infection Control Practitioner in the selection of the low-level disinfectant. [s. 87. (2.1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s.91 in that while the observed hazardous substances were inaccessible to residents, they were not labeled properly.

On April 29, 2014, Inspector #545 observed three unlabelled spray bottles containing liquids on a housekeeping cart on the first floor. These spray bottles had heavily worn labels, which rendered the name of the product, and product information, illegible. Discussion held with the housekeeping aide #S105 who indicated that spray bottles contained the following cleaning solutions: Profil #12 Ultra, Scrub E-Z and Vert-2-GO Bio. Housekeeping aide #S105 indicated that she knew this because she refilled these bottles from the mixing station in the Clean Utility room.

On April 29, 2014 Inspector #545 reviewed the Material Safety Data Sheet (MSDS)for the three spray bottles containing the cleaning solutions. The Environmental Services Supervisor (ESS) confirmed that the cleaning solutions identified by housekeeping aide #S105 were indeed: Profil #12 Germicide Ultra, Vert-2-GO All Purpose Cleaner and Scrub E-Z Acid Washroom Cleaner. Following further discussion with the inspector on this matter, the ESS reviewed the MSDS for all three cleaning solutions, and confirmed to the inspector that although in diluted form, the cleaning solutions remain hazardous. The ESS informed that as per the MSDS, Profil #12 Germicide Ultra was corrosive, Vert-2-GO All Purpose Cleaner was toxic and Scrub E-Z Acid Washroom Cleaner was both corrosive and toxic.

As such, the home did not ensure that all hazardous substances were labeled properly. [s. 91.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 s. 129 (1) (b) to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On April 29, 2014 Inspector #161 observed that in the unlocked fridge located in the locked medication room on the first floor, there were 4 vials of Lorazepam 4mg/ml; and in the unlocked fridge located in the locked medication room on second floor, there was 1 vial of Lorazepam 4mg/ml.

As such, the licensee failed to ensure that controlled substances are stored in a double-locked location. [s. 129. (1) (b)]

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Issued on this 6th day of May, 2014

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

KATHLEEN SMID