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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 30, 2015	2015_287548_0022	O-002153-15	Resident Quality Inspection

Licensee/Titulaire de permis

The Corporation of the 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

RUZICA SUBOTIC-HOWELL (548), KATHLEEN SMID (161), MEGAN MACPHAIL (551), RENA BOWEN (549)

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): September 14,15,16,17,18, 21 and 22, 2015.

Concurrently Logs#: O-001495-15 and O-000390-14 were completed.

During the course of the inspection, the inspector(s) spoke with the Residents, Family members, Administrator, Director of Care (DOC), Registered Nurses, Registered Practical Nurses, Personal Support Workers (PSWs), Environmental Services Supervisor, RAI Coordinator, Resident Care Coordinators #1 and #2, Housekeepers, Client Outreach Supervisor Registered Dietician, (representative) of the Resident's Council, Chair of the Family Council and Office Assistant.

During the course of the inspection, the inspector(s) toured resident care areas and non-residential areas, reviewed residents' health care records, reviewed infection control policies, environmental services policies, reviewed menus, zero tolerance of abuse and neglect policy, continence and bowel management program, fall prevention program, internal incident & investigation documentation, reviewed resident personal equipment cleaning schedules, observed residents meal service, and observed medication administration, reviewed maintenance program and records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

The home has six resident areas with a combination of shared and private rooms.

In three shared rooms, both resident's privacy curtain tracts run the length of the ceiling to the window. At the window the ceiling drops to accommodate a bay window. When the privacy curtains are fully drawn there is a gap of approximately three feet where there is no privacy curtain to provide sufficient privacy for either resident.

In two shared rooms when the privacy curtain is fully drawn there is a gap of approximately 3 feet where there is no privacy curtain to provide sufficient privacy for either resident.

The DOC accompanied the inspector to look at the privacy curtains in question on September 16, 2015 and confirmed that all five of the shared resident's rooms did not provide sufficient privacy for the residents in those rooms.

The DOC indicated to the inspector on September 17, 2015 that the home will complete an audit of the homes privacy curtains in all of the shared resident rooms to ensure sufficient privacy for all residents.

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 the licensee will ensure that every residents' bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 14. Every licensee of a long-term care home shall ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall. O. Reg. 79/10, s. 14.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident shower has at least two easily accessible grab bars, one grab bar located on the same wall as the faucet and one grab bar located on the adjacent wall.

The home has six resident areas with a resident shower on each unit. It was observed by Inspector #549 on September 14, 2015 during a tour of the home that all six resident showers had a heated grab bar adjacent to the same wall as the faucet however; there was no grab bar on the same wall as the faucet.

On September 17, 2015 during an interview with the Environmental Services Supervisor it was confirmed with Inspector #549 that all six of the resident showers do not have a grab bar on the same wall as the faucet. [s. 14.]

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 the licensee shall ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure as per O.Reg79/10, s.110 (7) that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

5. The person who applied the device and the time of application
7. Every release of the device and all repositioning.

Resident #004 was observed on a specified day in September, 2015 to be in a wheelchair with a front closure seat belt applied. The physician's order indicates a four point pressure buckle seat belt fastened at the front is to be applied for safety when up in wheelchair and removed at meal times.

Inspector #549 found that Resident #004 was not physically or cognitively able to undo a front closure seat belt. RN #111 confirmed with Inspector #549 that the seat belt

fastened at the front is considered a restraint.

On September 18, 2015 during an interview RN S#111 indicated to Inspector #549 that the PSW's document in PCC the application, release of the seat belt and the repositioning of the resident.

On September 21, 2015 during an interview RPN S#121 indicated to Inspector #549 that the PSW's document; once a shift the application and release of the restraint and repositioning of the resident.

A review of the restraint documentation for a specified period of time.was completed with the DOC and the inspector.

The documentation in PCC indicated that the PSW's document once a shift that the seat belt is being applied as ordered, released every 2 hours and restraint position checked hourly for safety.

Resident #024 was observed on two specific days in September, 2015 to be in a seated in a Broda chair with a front closure seat belt. The physician's order indicates that the front closure seat belt was for the prevention of sliding and rising unattended while in the the Broda chair and is to be removed at meal times.

Inspector #549 found the resident not physically or cognitively capable of undoing the front closure seat belt. RPN #S126 confirmed with Inspector #549 that Resident #024 is not capable of undoing the front closure seat belt. RPN #S126 confirmed with Inspector #549 that the front closure seat belt for Resident #024 is considered a restraint.

A review of Resident #024's restraint documentation for the time period of September,2015 indicated that the PSW's document once a shift that the seat belt is being applied as ordered, released every 2 hours and restraint position checked hourly for safety.

On September 22, 2015 during an interview with the Resident Care Coordinator #2 it was indicated to Inspector #549 that the expectation is for the PSW to document the application of the restraint, every release and repositioning of the resident at least every two hours.

During an interview the DOC confirmed with Inspector #549 that every application and

every release of a restraint and repositioning of the resident is not documented.

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 the license will shall ensure that the following is documented: the person who applied the device at the time of the application and every release of the device and all repositioning, to be implemented voluntarily.

WN #4: 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 ensure that drugs are stored in an area or medication cart that is used exclusively for drugs and drug-related supplies.

On September 21, 2015 on the 2nd floor unit at approximately 1055 hours it was observed in a hallway a treatment cart was stationary in front of a resident's room with no staff member present.

It was observed that there were three medication cups on the top of cart. Two medication cups held yellow pudding substance and plastic spoons. One medication cup had an identifying resident name on it. This medication cup contained four different types of tablets (drugs)underneath the pudding, the second medication cup contained two red pills with a plastic medication cup on top of it filled with 30 millilitres of an orange substance and, the third paper medication cup had yellow pudding with a spoon placed inside the cup. There was no identification on the two of the medication cups. In addition, a container of Betaderm 0.1% solution was on top of the cart with a label identifying a resident.

During the observation period the there was a resident seated in a wheelchair approximately 5-6 feet away and housekeeping staff were in the hallway cleaning. The inspector observed a staff member exiting a resident's room at 1059 approximately 15 feet from where the cart stood. The staff member identified herself to the Inspector #548 as the Registered Practical Nurse (RPN). It was observed that the distance from the room the RPN had exited to where the cart stood that the RPN did not have clear view of the cart.

On September 21, 2014 during an interview RPN S#121 indicated that she was preoccupied with another resident and had left the treatment cart unattended while she was in the room. S#121 verified that all of the medication cups held drugs for three different residents. S#121 indicated that she is aware of the home's policy was not leave drugs unattended.

On September 21, 2015 the DOC confirmed that the home's expectation is that drugs are secure and locked and not to be left unattended. [s. 129. (1) (a)]

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 the licensee shall ensure the safe storage of drugs, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff.

The home has six resident Tub Rooms. All of the Tub Room doors are equipped with a lock. The Tub Room doors are also all equipped with door closures at the top of the door. Staff carry a key to the Tub Room doors during their shift to allow access to the Tub Room as required.

During a tour of the home on September 14, 2015 at 09:45 Inspector #549 observed that the following Tub Room doors were locked but not closed completely to allow the lock to engage; Tub Room door #1022, #1089 and #1205. On September 16, 2015 at 1:30 pm Inspector #549 observed Tub Room door #1089 locked but not closed completely to allow the lock to engage. On September 17, 2015 at 08:50 Inspector #549 with the Maintenance Services Supervisor observed Tub Room door# 1089 locked but not closed completely to allow the lock to engage.

During an interview with the DOC on September 16, 2015 it was confirmed with Inspector #549 that the Tub Rooms are considered non-residential areas, residents are only in the tub rooms under the supervision of the staff.

During an interview with the Environmental Services Supervisor on September 17, 2015 it was indicated to the inspector that the maintenance staff will adjust the Tub Room door closures so the doors will close completely to allow the lock to engage.

It was observed by Inspector #549 on September 22, 2015 at 10:30 that all Tub Room doors on all of the resident areas where closed and locked. [s. 9. (1) 2.]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The Licensee of a long-term care home shall ensure that the home, furnishings and equipment are kept clean and sanitary.

On September 14, 2015 Inspector #549 observed Residents #004 tilt chair to have debris on both arms, left pad behind calf and left foot pedal.

On September 15, 2015 Inspector #548 observed Resident's #038 wheelchair wheel wells to have a small amount of white particulate.

On September 17, 2015 Inspector #548 observed Resident's #4 tilt wheelchair arm pads and noted the area to have whitish coloured stain and brown coloured debris and a nickel sized dried reddish area on the resident's right foot pedal. Inspector #548 took two fingers and touched these areas and noted that all three areas were dry to touch.

On September 17, 2015 Inspector #548 observed Resident's #038 wheelchair wheel wells to have more white particulate on the wheel wells.

On September 17, 2015 during interviews PSW S#109 and RPN S#111 both indicated that the wheelchairs are scheduled for monthly cleaning. PSW S#109 indicated that the procedure on the unit is to spot clean as necessary and RPN S#111 indicated that only monthly cleaning is done. Both staff members provided Inspector #548 their unit's cleaning schedule.

The Monthly Cleaning Schedule for each unit was reviewed for September 2015. The schedule indicated that for Resident #004 their wheelchair was scheduled for cleaning on specific days during the month of September, 2015.

On September 18, 2015 Inspector #548 observed both wheelchairs to be in the same condition as prior observed.

On September 18, 2015 during an interview the DOC indicated that wheelchairs are to be cleaned on an on-the-spot basis and as scheduled.

WN #7: 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 ensure that the resident-staff communication and response system (call bell) is easily accessed and used by residents, staff and visitors at all time.

During a tour of the home on September 14, 2015 Inspector #549 observed a resident lounge area identified as Spruce Lane on the first floor where several residents were listening to music. It was observed by Inspector #549 that the call bell was easily seen however was not easily accessible for use by resident, staff and visitors at all times. It was also observed that the resident lounge area identified as Willow Lane where several residents where observed to be watching TV had a call bell visible but not easily accessible.

In both noted resident lounge areas there is a call bell visible behind the glass wall across the from the lounge area, however it is not accessible from the resident lounge area. To access the call bell a resident, staff or visitor would have to go down the hallway into the nursing station.

During an interview on September 16, 2015 the DOC confirmed with Inspector #549 that the call bell in the resident lounge area on Spruce Lane and Willow Lane is not accessible by residents, staff and visitors at all times.

During an interview with the Environmental Services Supervisor on September 17, 2015 it was confirmed with Inspector #549 that the call bell located in the nursing station is the call bell allocated for use in the resident lounge area. The Environmental Services Manager indicated to Inspector #549 that renovation where done at the nursing station and the lounge call bell was enclosed in the nursing station in error.

On September 17, 2015 at 2:30 pm Inspector #549 observed that the call bell in the Spruce Lane and Willow Lane lounges were moved to the outside of the nursing station and are now accessible by residents, staff and visitors at all times. [s. 17. (1) (a)]

2. The licensee has failed to ensure that there is a resident-staff communication and response system (call bell) available in every area accessible by residents.

The home is equipped with call bell system which is available at each bed, toilet and bath location.

Inspector #549 noted that the lounge area on the main floor identified as the Sun Room, which was observed to be used by residents for social gatherings with families and friends, working on puzzles and the computer, was not equipped with a call bell.

On September 16, 2015 Inspector #549 spoke with the DOC who confirmed the Sun Room is accessible by residents and does not have a call bell available.

On September 17, 2015 the Environmental Services Manager indicated that the home has initiated the process for installing a call bell in the identified Sun Room area. [s. 17. (1) (e)]

Issued on this 5th day of October, 2015

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

Original report signed by the inspector.