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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de soins de longue durée

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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
Nov 24, 2016	2016_287548_0024	013431-16	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), ANANDRAJ NATARAJAN (573)

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 20 ,21, 22, 23, 26, 27, 28, 29,30 and October 3, 2016.

Logs#:
027993-16- Plan of care
026674-16- alleged abuse
017109-16- Plan of care
027663-16- Plan of care
002739-15- alleged abuse
020152-16- Plan of care
034404-15- alleged abuse
002074-15- alleged abuse
02820-16- Plan of care
028289-16- alleged abuse

During the course of the inspection, the inspectors: toured resident care areas, reviewed residents' health care records, reviewed zero tolerance of abuse and neglect policy, fall prevention program, reviewed restraint policy, internal incident & investigation documentation and observed medication administration

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Registered Nurses (RN), Registered Practical Nurses (RPN), Resident Care Coordinator #110 and #111, Physiotherapist, Registered Dietitian, Client/Outreach Programs Supervisor, Personal Support Workers (PSWs), Family and Resident Council representatives, Recreation programmers, family members and residents.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **5 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #030's written plan of care sets out the planned care for the resident and also provided clear direction to staff specifically related to falls/safety needs while toileting the resident.

A critical incident report on a specified day in June 2016 indicated that resident #030 had an unwitnessed fall in the resident's bathroom. Furthermore, the report indicated that PSW #132 transferred resident #030 onto the toilet and left the resident unattended on the toilet and the resident fell to the floor. Resident #030 fall incident resulted in transfer to the hospital for further assessment.

During this inspection Inspector #573 spoke with RN #108, PSW #133 and PSW #134, all staff, indicated that resident #030 is not to be left unattended while on toilet / commode due to falls/safety needs.

A review of resident #030 progress notes indicated that on a specified in June 2016, the resident had a fall, due to self-transfer from bed to wheel chair. A safety huddle and Restorative care progress notes on a specified day in June 2016 identifies that resident #030 is at risk of fall due to self-transfer.

Inspector #573 reviewed resident #030 written plan of care that was in place at the time of the incident for toilet use and falls. It identified that the resident #030 is at high risk for falls. Furthermore, the written plan of care does not provide clear directions to the staff that resident #030 is not to be left unattended while on toilet /commode due to falls risk.

On September 29, 2016, during an interview with the home's Director of Care (DOC), who indicated to the inspector that the home conducted an investigation related to the resident #030's June 2016 fall incident. The DOC indicated to inspector that prior to the above falls there was a change in resident #030's health status. Resident's #030 toileting and safety needs regarding not to be left unattended while on toilet was not reported or communicated to the PSW #132. The DOC further indicated that at the time of fall, resident's #030 written plan of care did not provide clear directions to the staff regarding resident #030's falls/safety needs while toileting on toilet /commode.

Resident #030's written plan of care does not set out the planned care for resident #030's toileting/ safety needs and did not provide clear directions to the staff regarding that the resident #030 required to be not left unattended while on toilet /commode due to risk of falls. [Log# 020152-16] [s. 6. (1)]

2. The licensee has failed to ensure that care specified in the plan of care was provided to the resident.

Related to Log#: 027663-16 regarding a medication incident.

A critical incident report was submitted on a specified day in September 2016 to the MOHLTC reporting an error in the administration of a medication that altered a resident's health care status.

Resident #034's co-morbidities require that the resident be administered continuous oxygen. A physician order dated for a specified day in January 2016 indicated the rate of Oxygen administration via nasal prongs.

The resident's care plan dated for a specified day in August 2016 indicated that medications are to administered as ordered as it related to the co-morbidities.

On a specified day in September 2016, in the morning, the resident was accompanied by a family member for a followup appointment outside the facility with a portable Oxygen tank. In the afternoon, on the same day, the home was informed that the resident began to exhibited signs of having difficulty of breathing and that the portable Oxygen tank was empty. No secondary tank accompanied the resident. The resident was brought to a nearby hospital for assessment in the emergency department and returned to the home the same day.

On October 3, 2016 the DOC indicated that the registered nursing staff are expected to monitor the Oxygen level in the tank and to ensure that the resident have a sufficient amount for transportation away from the home.

Later that same day the resident returned to the home with no apparent distress. [s. 6. (7)]

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 the written plan of care is provided as specified, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's policy to promote zero tolerance of abuse and neglect of residents was identified as the Prevention of Abuse and Neglect – Policy # G-006. Within the policy under Mandatory Reporting of Abuse or Neglect it states "Anyone who witness any form of abuse/ inappropriate care or is aware of alleged or suspected abuse/ inappropriate care is responsible for reporting it to their supervisor or designate immediately.

A critical incident report was submitted on a specified day in September 2016 that indicated that resident #029's call bell was deliberately placed out of reach by PSW staff

members. The CIR indicated a home's internal investigation was initiated immediately.

On a specified day in September 2016, Inspector #573 reviewed home's internal investigation report, upon review it was noted that PSW #127 observed resident #029's call bell was deliberately placed out of reach by PSW #128 and that it was reported to the registered staff numerous times. Furthermore, in the investigation report PSW #129 indicated that she had also observed resident #029's call bell was placed out of reach by PSW #128 and she had to go back and give the call bell to the resident.

On September 30, 2016, Inspector #573 spoke with RCC #110, who indicated that during an internal investigation related to resident #005, the management became aware of the resident #029's call bell, was deliberately placed out of reach by PSW #128 staff member. Furthermore, she indicated that the other staff members on the unit did not report immediately to any immediate supervisor designate or management staff until the home's management conducted an investigation in relation to resident #029. [Log# 028280-16]

A critical incident report was submitted on a specified day in December 2015 to the Director for a staff to resident alleged verbal abuse.

On a specified day in December 2015, in the home's secured unit, PSW #135 witnessed RN #120 speaking in an inappropriate tone and was being aggressive while providing care to the resident #026. PSW #135 reported the incident two days after the incident occurred to the home's Director of Care. An internal investigation was initiated immediately, and later concluded that RN #120's behaviours and interactions with resident to be inappropriate and bordering on being perceived as abusive.

On September 29, 2016 inspector#573 spoke with the home's DOC, who indicated to Inspector #573 that the incident, as described above, should have been reported by PSW #135 immediately to the Charge Nurse (Immediate Supervisor/ designate) who was working at that time, as per the home's policy to promote zero tolerance of abuse and neglect.[Log# 034404-15] [s. 20. (1)]

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 the policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to minimize the restraining of residents is complied with.

On September 27, 2016, at the request of Inspector #573, the Home's Director of Care (DOC) provided the home's Restraint Policy SOP#N-19-008, Review date, November 19, 2015.

Inspector reviewed Restraint Policy SOP#N-19-008, under preamble it indicates that physical restraints are used in accordance with manufacturer's specifications and directions.

Under Documentation / Individualized care plan the policy indicates that Registered Staff will –"Reassess the resident condition, effectiveness of the restraint, need for ongoing restraint, and potential to employ a less restrictive restraint at a minimum of every eight (8) hours and more frequently as determined by the circumstances or residents' condition and document in Point of care (POC)".

Personal Support Workers (PSWs) – "to complete Documentation on Point of Care (POC) is to be done for EVERY restraint release and for EVERY repositioning. At a minimum of every two hour or according to the resident individualized care that the resident was released and the resident was repositioned".

On a specified day in September 2016, Inspector #573 observed resident #019 sitting in a wheelchair with a front closing lap belt that was not positioned across the hips and had approximately more than six (6) inches gap between the lap belt and the resident's hips.

On a specified day in September 2016 at approximately 1115 hours, Inspector #573 observed resident #019 sitting in a wheelchair with a lap belt that was not positioned across the hips and had approximately more than eight (8) inches gap between the lap belt and the resident's hips. Resident #019's wheelchair lap belt was examined by RN #108 in the presence of the inspector, RN #108 indicated to inspector that the resident's seat belt was loose and immediately readjusted the front closing lap belt to fit the resident.

On September 26, 2016, Inspector #573 spoke with RN #108 regarding resident #019's front closing wheelchair lap belt. The RN #108 indicated to the inspector that the wheelchair lap belt was used as restraint for resident#019's safety to prevent falls. Resident #019's health care records were reviewed by the inspector, the use for wheelchair lap belt was identified as physical restraint for resident #019.

Inspector reviewed manufacturers' instructions for the specific lap belt which indicated "Keep belt tightened during fitting, and maintain this tightness during daily use to ensure correct placement. For padded hip belts, the pads will touch when fully tightened".

On September 26, 2016, the home's physiotherapist indicated to the Inspector #573 that the expectation regarding the application of the wheelchair lap belt was that it should be one or two fingers gap between the lap belt and the resident's hips. Furthermore, he indicated that the lap belt had to be a snug fit, so that it prevents the resident from sliding out from the wheel chair.

During this Inspection, Inspector #573 spoke with DOC, who indicated that the residents with restraints are monitored hourly by the PSW staff who document the application, release and repositioning of the resident in the POC. Furthermore, she indicated that the registered nursing staff must record the resident's response and the effectiveness of the restraint every eight hours in the POC.

On September 27, 2016, Inspector #573 reviewed the POC documentation for the specific time period in September 2016 for resident #019, in the presence of DOC. Upon review it was observed that when the wheel chair lap belt was in use, the documentation did not capture the repositioning of resident for several identified dates and time periods in September 2016. Furthermore, it was observed that the registered nursing staff documentation on two days in September 2016 during the day and for several days during in the same month during the evening hours for the resident #019's response and the effectiveness of the restraint every eight hours was not documented, as per the home's policy.

The home was not in compliance with their restraint policy regarding the application of the lap belt restraint for resident #019, to ensure that all repositioning and every eight hour requirement for reassessment and evaluation of resident #019's condition and effectiveness of restraining a resident is documented. [s. 29. (1) (b)]

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 is hereby requested to prepare a written plan of correction for achieving compliance specific to their Restraints policy by ensuring that all staff are aware of when a resident is to be restrained, that restraints are applied as per manufacturer instruction and to ensure that the repositioning of the resident and every eight hour requirement for reassessment and evaluation of resident condition and effectiveness of restraining a resident is documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to assess altered skin integrity using a clinically appropriate tool specifically designed for skin and wound.

The home's policy: Skin and Wound Program, N-17-006, Revision Date: September 26,2016, page 4 specifies that upon discovery of a pressure /statis ulcer a baseline assessment using a clinically appropriate assessment instrument called the Wound Assessment and Treatment Record is to be initiated.

On September 27,2016 the Director of Care and RN # 120 both indicated that altered skin integrity is any change in the condition and structure of the skin including redness. In addition, the Director of Care indicated that the Wound Assessment and Treatment Record was no longer in use as the home made a change in the last year to record all initial and ongoing assessments to describe altered skin integrity as per the assessment record tool in the electronic progress notes. The DOC indicated that the wound assessment must include: wound base, size, exudate, odor, pain and periwound status.

A progress note entry dated for a specified day in December 2015 indicated that resident #021 had voiced that he/she was slouching in his/her chair to relieve the pressure to the sore portions of his/her bottom.

On a specified day in January 2016 a progress note entry indicated a treatment was applied to an open area to a specific area. Several days later on a specified day in January 2016 a progress note entry indicated that the resident is exhibiting two open areas to a specific area. The one side measurement is documented and the opposite side is also described.

A progress note entry dated for a specified day in February 2016 titled MDS Evaluation Statement identifies the alteration as a stageable ulcer. Treatment was applied.

On a specified day in April 2016 the progress note entry indicted that the resident complained of pain stating the area was "very sore and uncomfortable", where the ulcer was. A progress note entry a few days later indicated that the resident "continues to have an open area.

The resident's#021 Minimum Data Set assessment (MDS) completed on a specified day in May 2016 indicated the resident was presenting with an escalated stageable ulcer.

On a specified day in June 2016 a Head to Toe Skin Assessment was conducted and the two pressure ulcers measurements were documented.

A progress note entry dated for a specified day in August 2016 titled MDS Evaluation Statement indicated the stage of the pressure ulcer for a specific area.

Review of the resident's health record resulted in no skin and wound assessment using a clinically appropriate tool specifically designed for skin and wound assessment and one progress note entry describing the wound. Staff interviewed did not comment as to why the wound assessments were not conducted. [s. 50. (2) (b) (i)]

2. The licensee failed to assess altered skin integrity using a clinically appropriate tool specifically designed for skin and wound.

The resident's #022 Minimum Data Set assessment (MDS) completed on a specified day in July 2016 indicated that the resident was presenting with a stageable pressure ulcer.

On a specified day in July 2016 a progress note entry titled: Annual Health Review documents that there are no alterations in skin to be observed.

A progress note entry dated several days later indicated that treatment was provided to an area of alteration to a specific area. The area was described to be open and not deep.

A few days later, a progress note entry indicated that a treatment was applied to a distinct area of altered skin integrity.

There was no record of the wound description in the resident health care record. Staff interviewed made no comment as to why the skin and wound assessment was not conducted. [s. 50. (2) (b) (i)]

3. The licensee failed to assess altered skin integrity using a clinically appropriate tool.

Resident #029 requires one person assistance with personal care and toileting.

It is recorded on the Interdisciplinary Care Conference on a specified day in February 2016 that the resident is identified for a risk of altered skin integrity.

On a specific day in June 2016 the RCC #110 was informed by the residents family member of a distinct area that presented with reddness.

In these three instances, there is no record of a skin and wound assessment using a clinically appropriate tool designed specifically for skin and wound assessment. [s. 50. (2) (b) (i)]

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 those residents exhibiting altered skin integrity are assessed using a clinically specific skin and wound assessment tool, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to immediately report an alleged abuse.

Related to: Log#: 028289-16

An incident critical incident report was reported to the MOHLTC on a specific day in September 2016 for an of alleged staff to resident verbal and physical abuse incident a few prior to the report.

On an identified day in September 2016 a PSW #136 witnessed PSW #137 not provide the resident sufficient time to position themselves in bed before lifting the resident's legs up high and abruptly placing them on the bed.

On October 3, 2016 during an interview PSW #136 indicated the incident was reported to her superior RPN #138 on the same night or the next evening.

On October 3, 2016 during an interview the RPN #138 indicated that the incident was reported to her on a few days after the incident and she proceeded to inform the DOC through email communication that same day.

On October 3, 2016 during an interview the resident indicated that he/she likes to position himself/herself on the bed and felt that the PSW had lifted his/her legs to high and was not provided sufficient time to adjust his/her position in bed.

The home investigation concluded that the PSW#137 conduct was unprofessional and disciplinary actions were taken.

The home was made aware of an alleged incident of abuse and did not immediately report. [s. 24. (1)]

Issued on this 7th day of December, 2016

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

Original report signed by the inspector.