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

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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 4, 2019	2019_593573_0006	016618-18, 017069-18, 020243-18, 020955-18, 024522-18, 024875-18, 027172-18, 029077-18, 029552-18, 033002-18	Critical Incident System

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

ANANDRAJ NATARAJAN (573), JANET MCPARLAND (142)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 11, 12, 14, 19, 20, 21, 25, 26 and 27, 2019.

The following Critical Incident Logs was inspected during this inspection:
Log #016618-18, Log #017069-18, Log #027172-18, Log #020243-18 and Log #024522-18 related to incident that causes an injury to a resident for which the resident is taken to hospital and that resulted in a significant change in the resident health status.
Log #029077-18 and Log #029552-18 related to alleged resident to resident sexual abuse.
Log #020955-18 and Log #033002-18 related to missing medication.
Log #024875-18 related to improper care of a resident that results in risk to a resident.

During the course of the inspection, the inspector(s) spoke with the residents, Recreation Assistant, Physiotherapy Assistant, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Occupational Therapist, Administration Supervisor, the Client/Outreach Programs Supervisor, the Resident Care Coordinators (RCCs), the Director of Care (DOC) and the Director of Long-Term Care.

During the course of the inspection, the inspector reviewed Critical Incident (CI) reports, residents' health care record and home's internal investigation documentation, as applicable. Reviewed licensee's relevant policies and procedures, In addition the inspector observed the provision of care and services to residents, observed staff to resident interactions and observed resident to resident interaction.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

2 WN(s)
1 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	Légende 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long term care home to have, institute or otherwise put in place any procedure the licensee is required to ensure that the procedure, is complied with.

A review of the licensee's Volunteer Manual revised Date May 2015, page 15 of 21, under General Information for wheelchair procedures, point 1, indicated that "make sure the resident's feet are on the foot rest, if there are no footrest, ask a staff member".

A review of the licensee operating procedure entitled Volunteer porters (Assisting to and from programs) SOP #: AC-074, revised date Nov 15, 2018. Under procedure, point 5, indicated that "ensue resident wheelchair is equipped with foot pedals. If in questions, please check with nursing staff prior to protering resident".

A review of Critical Incident Report indicated that on a specified date, recreation student #111 transported resident #001 in a wheelchair without foot rests in place. During the transportation, the resident's was injured. The resident was sent to the hospital for further management.

On February 12, 2019, Inspector spoke with RPN #106, who indicated that on a specified date, while resident #001 was being portered in a wheelchair by recreation student #111, the resident was injured. RPN #106 indicated that the recreation student portered the resident's wheel chair without the foot rests.

On February 12, 2019, Inspector spoke with Client/ Outreach Programs Supervisor, who stated that recreation student #111 was a student who was doing co-op placement at Bonnechere Manor. Furthermore, the Client Programs Supervisor stated that one of the responsibility of the recreation student #111 was to porter the residents to the activities.

On February 14, 2019, Inspector #573 spoke with RCC #107, who stated that they spoke with recreation student #111 after the incident. RCC #107 indicated to inspector that they were not aware if recreation student checked with the staff member to use the wheel chair foot rests prior protering resident #001 to the activity.

On February 19, 2019, during an interview with Occupational Therapist #112, they indicated to Inspector #573 that for safe positioning devices/ techniques while transporting residents in wheelchair resident's legs should be supported on the wheelchair foot rest.

On February 19, 2019, Inspector #573 spoke with the DOC, who stated that recreation student #111 was provided with the orientation/ duties within the aspects of voluntary services. Further, the DOC indicated that recreation student #111 was provided with the training to use the wheelchair foot rests while portering resident and the expectation was to follow the procedures/ training. (Log #016618-18) [s. 8. (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 ensuring that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #2: 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. (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 has failed to ensure that the care set out in the plan of care was provided as specified in the plan.

On a specified date, Critical Incident Report (CIR) was submitted to the Ministry of Health and Long -Term Care related to improper/ incompetent treatment of a resident that resulted in harm or risk to a resident. The CIR report indicated that resident #002 sustained a skin tear and bruising/ discolouration to a specified body part.

Inspector #573 reviewed resident #002's MDS assessment dated on a specified date, which indicated that the resident required two person total assistance for bed mobility and personal hygiene. A review of resident #002's written plan of care in place at the time of incident for personal hygiene and responsive behaviours (resistive to treatment/care) indicated that the resident required total assistance with two staff during the care.

On February 20, 2019, Inspector #573 spoke with PSW #114 who provided direct care to resident #002. PSW #114 stated that on a specified date, on their shift, resident #002's personal hygiene and bed mobility was provided with one person without the second staff assistance. Further, the PSW #114 acknowledged that they were aware that resident #002 required total assistance with two staffs during the care.

On February 20, 2019, Inspector #573 spoke with RCC #104, who stated that resident #002 was assessed and treated for the skin tear and bruising. RCC #104 indicated to the inspector that an immediate investigation was conducted on this incident involving resident #002. Furthermore, the RCC stated that as a result of the investigation, it was found PSW #114 failed to follow resident #002's care plan for personal hygiene and responsive behaviours on a specified date.

As such, PSW #114 did not provide the care set out in the plan of care to ensure that resident #002 was a two person total assistance for personal hygiene/ responsive behaviours.(Log #024875-18) [s. 6. (7)]

Issued on this 4th day of March, 2019

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

Original report signed by the inspector.