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

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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
Nov 7, 2019	2019_770178_0022	013128-19, 015172-19, 015267-19, 016971-19, 018105-19	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

SUSAN LUI (178)

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): October 10, 11, 15, 16, 17, 18, 21, 22, 23, 25, 2019.

Logs # 013128-19/M506-000013-19, 015172-19/M506-000016-19, 016971-19/M506-000020-19, and 018105-19/M506-000022-19, all involving falls with injuries were inspected.
Log #015267-19/M506-000017-19 regarding an unexplained injury was inspected.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers, Rehabilitation Assistants, Registered Practical Nurses, Registered Nurses, Resident Care Coordinators, and the Director of Care.

During the course of the inspection, the inspector also reviewed resident health records, reviewed the licensee's records of investigations, reviewed the licensee's policies, observed residents, their rooms, and resident care.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **4 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff who provided direct care to resident #002 were kept aware of the contents of the resident's plan of care.

This non-compliance was in regards to Log #015267-19/M506-000017-19.

Resident #002's plan of care indicated that the resident required assistance with all activities of daily living and was to be transferred with the assistance of two persons using a mechanical lift, with the lift sling positioned in a specified manner. During interviews with inspector #178, PSW #104 and PSW #111 indicated the lift sling was to be positiioned in a specified manner for resident #002 as a comfort measure.

On an identified date, resident #002 changed rooms to another unit within the home. PSW #009 indicated during interview with Inspector #178 that on resident #002's first day on the new unit, they were unaware of the resident's transfer status, and they and their partner transferred resident #002 using a mechanical lift, but did not position the sling in the manner specified in resident #002's plan of care. PSW #009 indicated that they had not been informed that resident #002's sling was to be positioned in a specified manner, and they did not have time to review the resident's plan of care before transferring the resident from chair to bed. [s. 6. (8)]

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 staff who provide direct care to residents are kept aware of the contents of the resident's plan of care, to be implemented voluntarily.

WN #2: 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 Regulation required the licensee of a long-term care home to have, institute or otherwise put any procedure in place, the procedure was complied with.

This non-compliance was in regards to Log #015267-19/M506-000017-19.

In accordance with O. Reg. 79/10, s. 50 (1) the licensee was required to have a skin and wound care program that provided strategies to promote resident comfort and mobility and promote the prevention of infection, including the monitoring of residents.

Specifically, staff did not comply with the licensee's "Bruising Assessment Protocol" Standard Operating Procedure (#N-9-032, revised August 27, 2019), which was part of the licensee's Skin and Wound Care program that required registered staff to complete the Bruising Assessment Protocol form and document in Point Click Care (PCC) progress notes that the bruising assessment protocol has been initiated whenever a resident was found to have an unexplained bruise.

Review of the licensee's Bruising Assessment Protocol, Standard Operating Procedure (SOP) #N-9-032, indicated that it is the responsibility of Registered Nurses, Registered Practical Nurses and Personal Support Workers to report any bruising noted during care, report any known incidents where bruising may result, and report changes in existing bruising. Where bruising is evidenced, Registered staff will complete the Bruising Assessment Protocol form and document in Point Click Care (PCC) progress notes that bruising assessment protocol has been initiated, and assess every five days and document the status of the bruise until resolution.

The DOC indicated to Inspector #178 that when unexplained bruising is observed on a resident, it should be documented by the PSW in Point of Care (POC) and by registered staff in PCC progress notes, and the Bruising Assessment Protocol should be initiated in the Treatment Administration Record.

PSW #111 indicated to Inspector #178 that resident #002 had bruising in a specified location when the resident first moved to PSW #111's unit on a specified date. PSW #111 indicated the bruising was reported to the registered staff by their PSW partner but could not remember which nurse this was reported to.

PSW #103 documented in Point of Care (POC) on a specified date, that resident #002 exhibited discolouration. During an interview with Inspector #178, PSW #103 indicated that at this time resident #002 had bruising in a specified location. PSW #103 indicated that they remember reporting the bruise to a registered staff member who was already aware of it. PSW #103 could not remember the specific registered staff member to whom they reported the bruise.

Resident #002's PCC progress notes were reviewed for the dates that PSW #111 and PSW #103 indicated they saw and reported bruising on resident #002, and there was no documentation present in the progress notes regarding bruising on these dates. No skin assessments or Bruising Assessment Protocol forms were found in the health record for resident #002 for the dates that PSW #111 and PSW #103 indicated they observed and reported bruising on the resident.

As such, the licensee failed to ensure that staff complied with the licensee's "Bruising Assessment Protocol" Standard Operating Procedure. [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 to ensure that where the Regulation requires the licensee of a long-term care home to have, institute or otherwise put any procedure in place, the procedure is complied with, to be implemented voluntarily.

WN #3: 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 has failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies, and is secure and locked.

This non-compliance was in regards to Log #015267-19/M506-000017-19.

Prescription topical creams were observed at the bedsides of three residents during the inspection period. Inspector #178 observed an identified prescription gel in the bedside drawer of resident #002 on October 21, 2019. On October 25, 2019, Inspector #178 observed an identified prescription cream on the bedside table of resident #007. On October 25, 2019, Inspector #178 observed an identified prescription cream on the counter in resident #008's washroom, a washroom shared with another resident.

PSW #128 and RPN #117 indicated that prescription creams should not be stored in residents' rooms or washrooms, and are to be stored in the locked utility room on the unit. [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 to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies, and is secure and locked, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

This non-compliance was in regards to Log #015267-19/M506-000017-19.

In an Interview with inspector #178 on October 18, 2019, PSW #111 indicated that PSWs apply an identified prescription gel to resident #002 twice daily.

Review of resident #002's Kardex on Point of Care (POC), which PSW staff can access to determine a resident's plan of care, indicated that the identified prescription gel should be applied to resident #002 prior to care/transfer. Review of PSW documentation on POC indicated under a PSW task titled Prescription Creams that the PSW is to apply the identified prescription gel to resident #002 twice daily. PSWs documented with check marks to indicate they completed this task twice daily over the past month. Review of the physician orders for resident #002 indicated that the identified prescription gel has not been prescribed for the resident since prior to September 2019. RPN #116 and RPN #117 indicated to Inspector #178 on October 21, 2019, that resident #002 has no current physician order for the identified prescription gel.

As such, the licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

Issued on this 26th day of November, 2019

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

Original report signed by the inspector.