Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jul 21, 2020	2020_559142_0006	002784-20, 004404-20, 008145-20	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

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): July 9, 10, 14, 15 (off-site), 16 (on-site) 17 (off-site), 2020

This inspection included the following critical incident reports (CIR):
-Log #002784-20 (CIR #M506-000004-20) and Log #004404-20 (CIR #M506-000009-20) related to incidents that caused injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status
-Log #008145-20 (CIR #M506-000010-20) related to a medication incident

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Resident Care Coordinator (RCC) and the Director of Care (DOC).
During the course of the inspection, the inspector reviewed residents health care records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication

During the course of this inspection, Non-Compliances were issued.
- **1 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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to resident #003 in accordance with the directions for use specified by the prescriber.

Critical incident report #M506-000010-20 was reported to Ministry of Long-Term Care on an identified date regarding a medication incident. On an identified date, during the administration of resident #003's medication, it was noted that resident #003's medications were missing from the medication batch. Upon investigation registered staff found,in the disposal bin, empty medication pouches for medications that were given at a specific time and date and for medications scheduled to be given at specific times and dates.

In a review of resident #003's medication administration record (MAR) for an identified month, their medications included specific medications that were to be administered at different times during the day. On an identified date and time, resident #003 received medications that were scheduled to be administered at a later time during that day and the following day.

In an interview with RPN #102, they indicated to Inspector #142, that they did not realize that they had administered resident #003's medications that were scheduled to be administered for a later time during the day and the following day until the error was discovered. RPN #102 indicated they must have been distracted while administering resident #003's medication resulting in the medication incident.
(Log #008145-20) [s. 131. (2)]

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 administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 21st day of July, 2020

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

Original report signed by the inspector.