Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
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Original Public Report

Report Issue Date: May 10, 2023

Inspection Number: 2023-1532-0003

Inspection Type:
Complaint
Critical Incident System

Licensee: The Corporation of the County of Renfrew

Long-Term Care Home and City: Bonnechere Manor, Renfrew

Lead Inspector	**Inspector Digital Signature**
Anandraj Natarajan (573)	Anandraj Natarajan Digitally signed by Anandraj Natarajan Date: 2023.05.12 09:41:13 -04'00'

Additional Inspector(s)
Marko Punzalan (742406)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 28, 2023, and May 1, 2, 3, 4, 2023.

The following intake(s) were inspected:
Intake: #00084992 - Complaint /concerns related to care and services to the resident.
Intake: #00016259 - Fall of a resident resulting in a significant change in health status.
Intake: #00086507 - Improper care resulted in the risk of harm to the resident's health status.
In addition, Intake: #00021251 - related to a resident's fall resulting in a significant change in health status was completed during this inspection.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c).

The licensee has failed to ensure that the written plan of care set out clear directions to staff and others who provide direct care to the resident specifically related to the resident's oral/denture care.

Rationale and Summary: The resident's progress note records indicated that the resident's denture was found in their throat, and they were sent to the hospital for further treatment. The resident returned from the hospital on the same day and was placed on palliative care.

The Inspector reviewed the resident's written plan of care in place at the time of the incident. The written plan of care for the resident identified that the staff were to complete the oral care but did not provide any directions related to denture care and its use.

An interview with the PSW identified that the resident had dentures. Furthermore, stated that they did not remove the resident's dentures at bedtime the night before the incident.

An interview with the RPN acknowledged that the resident's written plan of care did not provide any information about the resident's denture care and its use.

An interview with the RPN and a PSW stated that the resident's dentures should be removed and cleaned by the PSW staff at bedtime, but some nights they were left on.

An interview with the Resident Care Coordinator stated that there was a gap in the resident's written plan of care related to denture care. Furthermore, they indicated that the resident's written care plan did not provide clear directions to the staff about denture care and its use. The licensee has failed to ensure that the written plan of care for the resident set out clear directions to the staff regarding denture care and use which resulted in significant harm to the resident.

Sources: Resident's health care records, Hospital records, interview with the PSWs, RPNs, and the Resident Care Coordinator. [742406]

WRITTEN NOTIFICATION: Administration of Drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

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

Rationale and Summary: The Ministry of Long-Term Care received a complaint that the resident's medications were provided incorrectly by a Registered Nursing staff member. The resident's health care record identified the physician's Order for a medication regimen with the specific dosage, the schedule, and the duration of treatment. On a day in March 2023, an RPN administered an additional dose of five medications to the resident during their shift. The medications were provided incorrectly the doses were doubled on the day of the incident.

In an interview with the Administrator, they acknowledged that on a day in March 2023, the RPN had not administered the correct medications to the resident as specified by the physician. Failure to administer medications as prescribed poses a risk of harm to the resident.

Sources: The resident's health care records, the Medication Incident Report, and interview with the Administrator and other staff. [573]