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

Division des foyers de soins de longue durée
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
Aug 25, 2016	2016_287548_0021	019141-16	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

RUZICA SUBOTIC-HOWELL (548)

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): On August 22 and 23, 2016.

Related to log#: 019141-16- alleged staff to resident abuse.

During the inspection the inspector reviewed the home's investigative notes, resident health care record, observed staff to resident interactions and reviewed home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Director of Care, recreation programmer, registered nursing staff and personal support workers

The following Inspection Protocols were used during this inspection: Prevention of Abuse, Neglect and Retaliation

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

- **1 WN(s)**
- **0 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. 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 failed to immediately report an alleged staff to resident abuse.

Related to log#: 019141-16

A critical incident report was submitted to the MOHLTC on a specified day in June 2016 one day after a witnessed incident. The recreation programmer witnessed a personal support worker #100 feed resident #010 in a manner that causing the resident to choke and gag.

The health care record and the home's investigative notes were reviewed.

Resident #010 has dementia with cognitive loss, has been identified as a high nutritional risk and requires total feeding assistance with all meals.

The resident's #010 current care plan dated for a specified day in June 2016 was reviewed and it specifies that small bites of food are to be offered while assisted with feeding due to the risk of choking, reduced level of consciousness and the residents inability to sit upright.

The home's policy titled: Prevention of Resident Abuse and Neglect, Policy #: G-007, revision date: August 13, 2015 specifies to all staff the legislative requirements to immediately report alleged, suspected and witnessed abuse.

On August 23, 2015 during an interview the recreation programmer indicated that the incident was reported directly to the resident care coordinator the same day after the meal service was completed.

On August 23, 2016 the Director of Care indicated that both she and the Administrator where not onsite at the facility at the time of the incident and the resident care coordinator was the supervisor for the home in their absence. She indicated immediate reporting procedure is a component of the training all staff receive at the home. [s. 24. (1)]

Issued on this 25th day of August, 2016

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

Original report signed by the inspector.