



**Ministry of Long-Term
Care**

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

**Ministère des Soins de longue
durée**

**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

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
Nov 30, 2021	2021_770178_0023	015700-21	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): November 3, 4, 5, 8, 9, 15, 2021

**The following intake was completed in this Critical Incident System inspection:
Log #015700-21 was related to alleged abuse.**

During the course of the inspection, the inspector(s) spoke with the Administrator, Resident Care Coordinators (RCCs), Infection Prevention and Control (IPAC) Lead, Environmental Services Supervisor, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Recreation Programmer, Housekeeper, and residents.

During the course of this inspection, the inspector observed resident and staff interactions, infection prevention and control practices, reviewed clinical health records, relevant home policies and procedures, staff training records, and other pertinent documents.

**The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services
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)**

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****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. (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 to a resident as specified in the plan.

A PSW provided perineal care to a resident while the resident was standing up. The resident's plan of care indicated that perineal care should be provided while the resident is in bed. A Resident Care Coordinator (RCC) indicated that the resident's perineal care should be provided in bed to enable the staff to provide better care to the resident.

Sources: Interviews with a PSW and an RCC; a resident's clinical record, and the licensee's investigation notes. [s. 6. (7)]

Issued on this 2nd day of December, 2021**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs****Original report signed by the inspector.**