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 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: May 21, 2024	
Inspection Number: 2024-1532-0002	
Inspection Type: Critical Incident	
Licensee: The Corporation of the County of Renfrew	
Long Term Care Home and City: Bonnechere Manor, Renfrew	
Lead Inspector Marko Punzalan (742406)	**Inspector Digital Signature** Marko Punzalan Digitally signed by Marko Punzalan Date: 2024.05.23 17:14:04 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 7, 8, 9, 10, 13, 14, 2024

The following intake(s) were inspected:

- Intake: #00106463 - M506-000005-24 related to disease outbreaks.
- Intake: #00109071 - M506-000010-24 related to alleged emotional abuse to a resident by a staff member.
- Intake: #00112102 - IM506-000013-24 - related to a fall with significant injury.
- Intake: #00113431 - M506-000018-24 - related to alleged emotional abuse to a resident by a staff member.
- Intake: #00114769 - M506-000022-24 related to resident to resident physical altercation.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (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:

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.

The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident that resulted in harm or risk of harm has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

Rationale and Summary:

On a specific date, a Critical Incident Report (CIR) M506-000018-24 was submitted regarding an allegation of verbal abuse toward a resident by a staff member that occurred on a specific date.

Personal Support Worker (PSW) reported to the Resident Care Coordinator (RCC) that on a specific date, they witnessed an incident of verbal abuse by a staff member toward the resident but did not report the alleged incident immediately.

During an interview with RCC, they indicated that the alleged verbal abuse was not reported to the Director immediately.

As such, not reporting this incident of alleged abuse of the resident could potentially place the resident at risk of not receiving appropriate follow-up.

Sources: Critical Incident report #M506-000018-24 and interview with RCC. [742406]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to comply with their written procedure related to fall prevention and management for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) b, the licensee is required to ensure that their written policy related to fall prevention and management is complied with.

Specifically, staff did not comply with the licensee policy titled Falls Prevention and Management Program, NC-19-005 last reviewed May 19, 2023.

Rationale and Summary:

On a specified date, the resident reported to the staff they had fallen the night of the specific date.

During an interview, RPN indicated when the staff reported the resident's unwitnessed fall they initiated the fall assessment, including the Head Injury Routine (HIR) but it was not completed as per their policy.

A review of the resident's health care records confirmed HIR was initiated at 0745 hours followed by 0800 hours and 0815 hours but not after.

During an interview with the Resident Care Coordinator (RCC), they indicated that HIR should have been done every 15 minutes four times, followed by every 30 minutes for the next hour and hourly until the resident's condition stabilized.

Failing to complete the post-fall head injury assessment, placed the resident at risk of undetected injuries.

Sources: resident's health care records, and interview with RPN and RCC.
[742406]

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