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
Telephone: (877) 779-5559
ottawadistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: December 21, 2022	
Inspection Number: 2022-1532-0002	
Inspection Type: Critical Incident System	
Licensee: The Corporation of the County of Renfrew	
Long Term Care Home and City: Bonnechere Manor, Renfrew	
Lead Inspector Susan Lui (178)	**Inspector Digital Signature** Susan Lui Digitally signed by Susan Lui Date: 2022.12.29 14:55:06 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 30, December 1-2, 6-9, 12-13, 2022

The following intake(s) were inspected:

- Log #00004184-[CI: M506-000019-22] and Log #00008077-[M506-000025-22] regarding falls with injury
- Log #00013942-[M506-000034-22] regarding alleged resident to resident sexual abuse

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in the plan.

Rationale and Summary:

The plan of care for toileting a resident indicated that they were to be toileted using an assistive device with the assistance of two staff for the entire process.

The resident was toileted using the assistive device with the assistance of one PSW. The resident was unable to complete the transfer and was lowered to the floor. After the attempted transfer it was determined that the resident had sustained an injury.

At the time of the incident the PSW was unaware that the resident's plan of care required two persons to assist with toileting using the assistive device. The PSW indicated that they had not checked the resident's plan of care before the incident. They believed at the time that the resident could be toileted using the assistive device with one person assisting, because this is what other staff did, and the resident had been toileted this way without difficulty in the past.

This non-compliance caused harm to a resident as they sustained an injury.

Sources: Medical health record for a resident; interviews with a PSW, a Resident Care Coordinator, and other staff.

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