

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

Public Report

Report Issue Date: February 27, 2026
Inspection Number: 2026-1532-0002
Inspection Type: Critical Incident
Licensee: The Corporation of the County of Renfrew
Long Term Care Home and City: Bonnechere Manor, Renfrew

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 17, 18, 19, 20, 23, 24, 25, 26, 2026

The following intake(s) were inspected:

- Intake: #00168024 -Respiratory Outbreak
- Intake: #00168052 - Fall of a resident resulting in a significant injury
- Intake: #00168604 - Fall of a resident resulting in a significant injury
- Intake: #00169360 - Improper/Incompetent treatment of a resident by staff
- Intake: #00169677 - Enteric Outbreak

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

- Resident Care and Support Services
- Infection Prevention and Control
- Safe and Secure Home
- Reporting and Complaints
- Falls Prevention and Management

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

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 (7)

Plan of care

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.

A resident was deemed end of life care on a specified date in January 2026, by their physician. On a specified date in January, 2026, nursing staff, specifically personal support workers (PSW's) on shift, did not turn or reposition a resident every two hours as stated in their care plan to do so. An RPN did not assess a resident or administer pain medications every two hours as ordered, on a specified date in January 2026, for a period of four hours. The resident was not comfortable during this time period as reported by their substitute decision maker (SDM) to the home.

Sources: A resident's medical record, interviews with RAI Coordinator, two RN's, the DOC and other staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

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

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee did not follow any standard or protocol issued by the Director with respect to infection prevention and control. Specifically, on a specified date in February 2026, at a specified time, an RN was observed taking a nasopharyngeal swab from a resident, and they were not wearing eye protection which was posted as a standard additional personal protective equipment (PPE) requirement for contact/droplet precautions when providing care to the identified resident.

Sources: Inspector observations and interview with an RN.