

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: August 29, 2023 Inspection Number: 2023-1532-0004

Inspection Type:

Critical Incident

Licensee: The Corporation of the County of Renfrew

Long Term Care Home and City: Bonnechere Manor, Renfrew

Lead Inspector Shevon Thompson (000731) **Inspector Digital Signature**

Additional Inspector(s)

Karen Buness (720483)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 17, 18, 21, 22, 23, 2023.

The following intake(s) were inspected:

- Intake: #00087513 Fractured hip. Unknown cause.
- Intake: #00092277 Fall resulting in significant change due to a hip fracture.
- Intake: #00093900 Complaint received by home regarding medication errors.
- Intake: #00093916 Alleged neglect/abuse of residents by staff.

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services Infection Prevention and Control Prevention of Abuse and Neglect Reporting and Complaints Falls Prevention and Management



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INSPECTION RESULTS

WRITTEN NOTIFICATION: Complaints procedure - licensee

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

Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

Rationale and Summary:

The Licensee received a written complaint from family detailing concerns regarding a registered practical nurse's medication administration practices at 1400 hours. The home notified the Director the following day at 1437 hours. As per the FLTCA, 2021 legislation the licensee is required to immediately forward to the Director any written complaint that it receives concerning the care of a resident.

Sources: CIS report M506-000023-23, Employer Investigation Notes #020-17

[720483]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1. Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The Licensee has failed to immediately report suspicion of alleged abuse and neglect when it was reported on August 3, 2023.

Rationale and Summary:

During a morning in August, 2023, during interviews with three Personal Support Workers (PSW) and a Registered Practical Nurse (RPN) the Director of Care (DOC), was informed of alleged abuse and neglect of six residents. This was reported to the Director the following day at 1535 hours. As per the Fixing Long Term Care Act, 2021 s. 28. (1) 2. the licencee is required to immediately report any suspected abuse or neglect of a resident.



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Impact/Risk:

There is an increased risk of delay in the investigation when incidents of alleged abuse/neglect are not reported immediately to the Director.

Sources:

Ministry of Long-Term Care CIS Report #M506-000021-23, Employer Investigation Report Form #020-17

[000731]



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