



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des  
Soins de longue durée**

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

**Rapport d'inspection sous la  
Loi de 2007 sur les foyers de  
soins de longue durée**

**Health System Accountability and  
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**Division de la responsabilisation et de la  
performance du système de santé  
Direction de l'amélioration de la  
performance et de la conformité**

### **Public Copy/Copie du public**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Sep 4, 2014	2014_195166_0022	O-000791- 14	Resident Quality Inspection

#### **Licensee/Titulaire de permis**

Chartwell Master Care LP  
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

#### **Long-Term Care Home/Foyer de soins de longue durée**

BON AIR RESIDENCE  
131 Laidlaw Street South, Cannington, ON, L0E-1E0

#### **Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

CAROLINE TOMPKINS (166), CHANTAL LAFRENIERE (194), MATTHEW STICCA (553), SAMI JAROOUR (570)

### **Inspection Summary/Résumé de l'inspection**



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**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): August 18-22 and August 25-29 2014**

**During the course of this inspection ,complaint logs O-000329-13, O-000523-14 and critical incident logs O-000742-13, O-001133-13, O-001149-13, O-000825-14, O-000892-14 were inspected concurrently.**

**During the course of the inspection, the inspector(s) spoke with Residents, Family, Resident Council President, Family Council President, the Physician, Dietitian, Food Service Supervisor, Program Support Services Manager, Personal Support Workers(PSW), Registered Practical Nurses(RPN), Registered Nurses(RN),Dietary Aides, Housekeeping staff, Maintenance Manager, Assistant Director of Care (ADOC)/RAI Coordinator and the Administrator/Director of Care.**

**During the course of the inspection, the inspector(s) toured the home, observed dining and nourishment service, observed staff to resident interaction during the provision of care, observed medication administration pass, reviewed the minutes of the Resident Council and the Family Council meetings, observation of infection control practices,observed residents in activities. Reviewed the licensee's policies related to Abuse, Infection Control, Skin and Wound, PASD-Bed Rails, Contenance Care and Activities/Programs. Reviewed the licensee's internal investigation related to complaints and critical incidents.**

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



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**Accommodation Services - Housekeeping  
Accommodation Services - Maintenance  
Continence Care and Bowel Management  
Dignity, Choice and Privacy  
Dining Observation  
Family Council  
Food Quality  
Hospitalization and Change in Condition  
Infection Prevention and Control  
Medication  
Minimizing of Restraining  
Nutrition and Hydration  
Personal Support Services  
Prevention of Abuse, Neglect and Retaliation  
Recreation and Social Activities  
Residents' Council  
Responsive Behaviours  
Skin and Wound Care  
Sufficient Staffing**

**Findings of Non-Compliance were found during this inspection.**



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification  VPC – Voluntary Plan of Correction  DR – Director Referral  CO – Compliance Order  WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit  VPC – Plan de redressement volontaire  DR – Aiguillage au directeur  CO – Ordre de conformité  WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey**

**Specifically failed to comply with the following:**

**s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).**

**Findings/Faits saillants :**



1. The licensee has failed to seek the advice of the Residents' Council and the Family Council in developing and carrying out of the satisfaction survey.

Interview with the President of the Family Council indicated that the Council was not involved in the development and carrying out of the satisfaction survey.

Interview with Administrator/Director of Care indicated that the Family Council was not involved in the development of the 2014 survey.

Interview with the President of the Residents' Council indicated the licensee had provided a copy of the 2014 satisfaction survey for the Council to review, it was not the survey that was used.

Interview with the Administrator/Director of Care stated that the Resident Council was not provided the current 2014 satisfaction survey to review. [s. 85. (3)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring it seeks the advice of the Residents' Council and the Family Council in developing and carrying out the satisfaction survey, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents**



Specifically failed to comply with the following:

- s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,**
- (a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and**
  - (b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).**
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**Findings/Faits saillants :**

1. Log O-000892-14

The licensee has failed to ensure that the resident's Substitute Decision Maker was notified within 12 hours upon becoming aware of an alleged incident of staff to resident physical abuse.

On August 14, 2014, Staff #120 reported to the Administrator/Director of Care an alleged incident of staff to resident physical abuse which Staff #120 indicated they had witnessed between Staff #116 and Resident #14 on August 13, 2014.

The resident's Substitute Decision Maker was notified of the alleged incident of staff to resident physical abuse and the outcome of the investigation by the Administrator/Director of Care on August 25, 2014. [s. 97. (1) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance the licensee shall ensure that the resident's Substitute Decision Maker was notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse of a resident, to be implemented voluntarily.***



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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management**

**Specifically failed to comply with the following:**

**s. 51. (2) Every licensee of a long-term care home shall ensure that, (a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

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**Findings/Faits saillants :**

1. The licensee has failed to ensure that a resident who is incontinent received an assessment that: includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Review the of MDS – RAPs documentation indicated that Resident #20 has had a deterioration in urinary incontinence from occasionally incontinent to frequently incontinent of bladder.

Interview with Assistant Director of Care/RAI Coordinator indicated a continence assessment related to changes in residents' continence status is as follows:

- Personal Support staff complete a 5 day continence observation form.
- Registered staff will review the continence observation form and complete the bladder or bowel continence assessment.

The Assistant Director of Care/RAI Coordinator confirmed that a continence observation form and a bladder continence assessment was not completed for Resident #20 during the month January 2014 to assess the change in the resident's continence status. [s. 51. (2) (a)]

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act**



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**Specifically failed to comply with the following:**

**s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).**

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**Findings/Faits saillants :**

1. The licensee has failed to ensure that a report to the Director was made within 10 days of becoming aware of an alleged, suspected or witnessed incident of abuse of a resident.

The Administrator/Director of Care was made aware of an alleged incident of staff to resident physical abuse on August 14, 2014. The critical incident report was submitted to the Director on August 27, 2014. [s. 104. (2)]

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**Issued on this 4th day of September, 2014**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**