Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report under the
Fixing Long-Term Care Act, 2021

Central East Service Area Office
33 King Street West, 4th Floor
Oshawa ON L1H 1A1
Telephone: 1-844-231-5702
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Original Public Report

Report Issue Date September 28, 2022
Inspection Number 2022_1123_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
DTOC Ii Long Term Care LP, by its general partner, DTOC Ii Long Term Care MGP (a general partnership) by its partners, DTOC Long Term Care GP Inc. and Arch Venture Holdings Inc.

Long-Term Care Home and City
Bon Air Long-Term Care Residence, Cannington

Siu F Tang
2022.09.29 09:24:00 -04'00'

Lead Inspector
Eric Tang (#529)

Inspector Digital Signature

Additional Inspector(s)
Inspector #111 (Lynda Brown) was also present during this inspection.

INSPECTION SUMMARY

The inspection occurred on the following date(s): September 6-9, 12, 2022.

The following intake was inspected:
- An intake related to a fall with a significant change in condition.

The following **Inspection Protocols** were used during this inspection:
- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Safe and Secure Home

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 184 (1).

The licensee has failed to ensure that a Minister's operational or policy directive was followed related to masking.

In accordance to section 1.2 of the Minister's Directive dated April 27, 2022, licensees are required to ensure that the masking requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, or as amended, were followed.

Rationale and Summary
On one occasion, a staff was observed to be working without a mask in a non-residential area, but was noted to be wearing one later in the day. The Infection Prevention and Control (IPAC) lead confirmed that all staff were expected to be masked when working, unless they were in the breakroom for meal.

Sources: Staff observations; interview with the IPAC lead.

Date Remedy Implemented: September 6, 2022 (529)

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)*

The licensee has failed to implement any standard or protocol issued by the Director with respect to IPAC.

In accordance to section 10.4 (h) of the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes", April 2022, the licensee shall ensure support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting.

Rationale and Summary
During a meal observation, a few residents have entered the dining room and proceeded with their meals without being assisted with hand hygiene. The IPAC lead confirmed that staff were expected to assist residents with hand hygiene prior to receiving their meals.

Residents who consumed their meals without being assisted with hand hygiene posed a moderate risk and impact as the chain of infection was not eliminated, and may result in the further spread of infectious agents, such as, COVID-19 virus.

Sources: Staff and resident observations; interview with the IPAC lead. (529)

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WRITTEN NOTIFICATION [REQUIRED PROGRAMS]

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 57 (1) 4

The licensee has failed to ensure that the pain management program provided for the monitoring of the resident's response to the pain management strategies.

Rationale and Summary

The resident had experienced an incident and began to have pain. An intervention was provided to them, but their response to the intervention was not recorded. A pain assessment was completed later on indicating the resident continued to experience pain.

As per the home's pain management policy, staff were to contact the physician for alternate pain control measures if pain was not relieved with initial interventions.

Resident's records and an interview with the Director of Care confirmed that the physician was not contacted, as per the home's policy. The physician was notified at a later time when the resident was transferred to another facility for further treatment.

There was moderate risk and impact to the resident due to the presence of unrelieved pain. The resident might have received alternate pain control measures should staff contact the physician as per the home's pain management policy. The presence of pain might have also caused unnecessary suffering and affected their quality of life.

Sources: Resident's records, home's pain management policy; interview with the Director of Care. (529)