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 District
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Public Report

Report Issue Date: February 11, 2026
Inspection Number: 2026-1123-0001
Inspection Type: Critical Incident
Licensee: DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC II Long Term Care GP Inc. and Arch Venture Holdings Inc.
Long Term Care Home and City: Bon Air Long Term Care Residence, Cannington

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 5, 6, 9, 11, 2026
The inspection occurred offsite on the following date(s): February 10, 2026

The following intake(s) were inspected:

- An intake related to an alleged resident to resident abuse incident.

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

Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Right to freedom from abuse and neglect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 4.
Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to freedom from abuse.

A Critical Incident Report submitted to the Director confirmed a resident was abused by a cognitively impaired resident. There were no similar incidents noted prior or post this reported incident. The resident's right to freedom from abuse was not respected.

Sources: Critical Incident Report, residents clinical records, and interview with staff.

WRITTEN NOTIFICATION: When PASD may be used

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 36 (3)
PASDs that limit or inhibit movement
s. 36 (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care.

Two specific residents had a device in use as a Personal Assistance Services Device (PASD). There was no documentation in either residents' plan of care regarding the use of this device.

Sources: Observations, Resident Safety: Restraint policy and procedure, resident's clinical health records, and interview with staff.

WRITTEN NOTIFICATION: Requirements relating to the use of a PASD

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 120 (2) (b)
Requirements relating to the use of a PASD
s. 120 (2) Every licensee shall ensure that a PASD used under section 36 of the Act,
(b) is applied by staff in accordance with any manufacturer's instructions; and

During observations, PASD devices located in residents' room were found to be

inconsistently positioned, with varying distances between surrounding furniture. The manufacturer’s instructions of the device stated that the device must be installed with sufficient clearance to allow an individual to walk completely around it. Positioning the device too close to another object may result in entrapment. Such entrapment can lead to serious injury or death. Several residents were placed at risk of entrapment due to the improper placement of the PASD.

Sources: Observations, manufacturers instructions, and interview with staff.