Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
November 24 2010	2010_166_2613_29Nov154331	Log# O-002147

Licensee/Titulaire
Chartwell Master Care LP Fax 905-501-0813
100 Millverton Drive,Suite 700
Mississauga ON
L5R 4H1

Long-Term Care Home/Foyer de soins de longue durée
Bon Air Residence
131 Laidlaw Street South Fax 705-432-3331
Cannington,ON
L0E 1E0

Name of Inspector(s)/Nom de l'inspecteur(s)
Caroline Tompkins #166
Patricia Powers #157

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection related to treatment during the provision of care for a resident.

During the course of the inspection, the inspector spoke with: the Administrator/Director of Care, a registered nurse, and a personal support worker. The resident was not able to be interviewed at the time of this inspection.

During the course of the inspection, the inspector: reviewed the resident's clinical records, the witness statements related to the two separate dates the treatment occurred, the home's Resident Abuse Policy and observed the resident in the home area.

The following Inspection Protocol was used during this inspection: Prevention of Abuse and Neglect

Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007,c.8,s.19 (1) Every Licensee of a long- term care home shall protect residents from abuse by anyone and shall ensure that resident's are not neglected by the licensee or staff.

Findings:

1. Documentation identifies that two staff members advised they had observed a registered nursing staff on two separate occasions complete care for a resident while the resident was restrained .These events were reported to have occurred on September 29 and September 30 2010.
2. The home advised that during their investigation into these allegations, the registered nursing staff admitted to restraining the resident while providing care.

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WN #2: The Licensee has failed to comply with LTCHA ,2007,c8,s.20(1) Without in any way restricting the generality of duty provided for in section 19,every licensee shall ensure that there is a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

Findings:

1. The home has a written zero abuse policy that states "All staff members are required to report any abuse immediately to the Administrator, Director of Care or designate". The two incidents of restraining a resident during care occurred on September 29 and September 30 2010 and were not reported to the management of the home until October 6 and October 7 2010. the reporting time period did not comply with home's policy,

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Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). December 16 10