Ministry of Health and Long-Term Care

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Ottawa Service Area Office

347 Preston St., 4th Floor
Ottawa ON K1S 3J4
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Ministère de la Santé et des Soins de longue durée

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité
Bureau régional de services de Ottawa

347, rue Preston, 4iém étage
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Ontario

January 12, 2011

Ms. Sarah Zonnenberg
Administrator
Bon Air Residence
131 Laidlaw Street, South
Cannington ON L0E 1E0

Dear Ms. Zonnenberg:

Please find enclosed the ***Inspection Report-Public Copy*** for an inspection conducted on November 24, 2010 under the *Long-Term Care Homes Act, 2007* (LTCHA) for the purpose of ensuring compliance with requirements under the LTCHA.

This inspection report must be posted in the home, in a conspicuous and easily accessible location in accordance with the LTCHA, 2007, S.O. 2007, c.8, s.79 (1) and (2).

A copy of the ***Inspection Report-Public Copy*** must be made available without charge upon request. The report will also be on file with the Ottawa Service Area Office, Performance Improvement and Compliance Branch.

Sincerely,

Caroline Tompkins
LTC Home Inspector – Nurse

c President, Resident's Council
President, Family Council

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*

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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_29Nov15937	Log # O-002282

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

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

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection related to resident care.

During the course of the inspection, the inspector spoke with: the Administrator/Director of Care, a registered nurse, two personal support workers and the registered dietician.

During the course of the inspection, the inspector: reviewed the resident's clinical records.

The following Inspection Protocol was used during this inspection: Dignity, Choice and Privacy

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.6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

Findings:
1. The plan of care did not identify the resident's weight loss.
2. The plan of care did not address any interventions related to the resident's food and fluid intake.
3. There was no evidence to support that the staff were collaborating to assess and manage the resident's food and fluid intake and weight loss.

Inspector ID #:	#166

WN #2: The Licensee has failed to comply with LTCHA 2007, c. 8, s. 3 (1). Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted.
9. Every resident has the right to have his or her participation in decision –making respected.

Findings:
1. The resident's plan of care identifies that it was the resident's wish to be transferred to the hospital for further assessment if required. The resident was not transferred to the hospital when she requested.
2. The resident's family requested that the resident be transferred to the hospital. The resident was not transferred to the hospital until the family made a second request.

Inspector ID #:	166

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 23 2010