Ontario

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

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

London District
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Original Public Report

Report Issue Date: February 1, 2023	
Inspection Number: 2023-1243-0002	
Inspection Type: Complaint	
Licensee: ATK Care Inc.	
Long Term Care Home and City: Exeter Villa, Exeter	
Lead Inspector Melanie Northey (563)	**Inspector Digital Signature** Melanie Northey Digitally signed by Melanie Northey Date: 2023.02.01 09:37:48 -05'00'
Additional Inspector(s) NA	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 25, 27 and 30, 2023

The following intake(s) were inspected:

- Intake: #00003989 / Complainant IL-04509-LO related to resident discharge.

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

- Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION:

Requirements on Licensee Before Discharging a Resident

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (2) (d)

The licensee failed to ensure that before discharging the resident, the resident and the resident's family member was provided a written notice setting out a detailed explanation of the supporting facts, as they related both to the home and to the resident's condition and requirements for care, that justified the licensee's decision to discharge the resident.

Rationale and Summary:
The Director of Care (DOC) stated the resident and the resident's family member was not provided a written notice of discharge until a month after the resident's discharge.

There was a letter of discharge provided to resident and their family member approximately a month after the resident's discharge form the Long-Term Care home.

The resident and their family member were not provided a written notice before discharge. The resident and their family deserved a detailed explanation of the supporting facts and requirements for care, that justified the licensee's decision to discharge the resident and they did not receive it until over a month later.

Sources: review of discharge documentation and the clinical record for the resident and interviews with the DOC and Administrator.
[563]