



**Ministry of Health and
Long-Term Care**

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

**Ministère de la Santé et des
Soins de longue durée**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 9, 2013	2013_185112_0002	L-001832-12	Complaint

Licensee/Titulaire de permis

**DEVONSHIRE ERIN MILLS INC.
195 DUFFERIN AVENUE, SUITE 800, LONDON, ON, N6A-1K7**

Long-Term Care Home/Foyer de soins de longue durée

**LONGWORTH LONG TERM CARE FACILITY
590 Longworth Road, LONDON, ON, N6K-4X9**

**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs
CAROLE ALEXANDER (112)**

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 04, 2013

This inspection covers the following Logs: L-001832-12 & L-001674-12

**During the course of the inspection, the inspector(s) spoke with Director of Care,
Administrator and a Registered Practical Nurse**

**During the course of the inspection, the inspector(s) Reviewed the following: a
clinical record, a critical incident, the home's internal investigation, policies and
procedures related to prevention of abuse and neglect and related staff training.**

The following Inspection Protocols were used during this inspection:



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Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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 non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.)
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 148.
Requirements on licensee before discharging a resident**



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Specifically failed to comply with the following:

- s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,**
- (a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).**
 - (b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).**
 - (c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).**
 - (d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).**
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Findings/Faits saillants :

A resident was transferred to hospital on a leave of absence. The Licensee discharged the resident.

The Licensee did not ensure that alternatives to discharge had been considered in utilizing the allotted leave of absence time.

The Licensee did not provide a written notice to the resident's substitute decision-maker 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, to justify the licensee's decision to discharge the resident.

O. Reg. 79/10,s.148 (2)(a)(d)



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Issued on this 9th day of January, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

A handwritten signature in black ink, appearing to read "PSK".