Ontario

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 prévue le Loi de 2007 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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
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Bureau régional de services d'Ottawa
347 rue Preston bureau 420
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Sep 21, 2015;	2015_396103_0013 (A1)	O-001529-15	Complaint

Licensee/Titulaire de permis

2109577 ONTARIO LIMITED
195 Forum Drive Unit 617 MISSISSAUGA ON L4Z 3M5

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

2109577 ONTARIO LIMITED O/A ARBOUR HEIGHTS
564 Tanner Drive KINGSTON ON K7M 0C3

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

DARLENE MURPHY (103) - (A1)

Amended Inspection Summary/Résumé de l'Inspection modifié

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The licensee appealed the Director's Orders to the HSARB. As a result of a material change in circumstances, the Director is amending the Director's Decision dated May 1, 2015, and makes the following decisions in relation to the Inspector's Orders #001 and #002. Compliance Orders #001 and #002 are rescinded.

The Director's Decision, dated May 1, 2015, is being amended because there has been a material change in circumstances which means that the Inspector's Orders can no longer be complied with. As a result, the Inspector's Orders are revoked on the following grounds:

- As a result of a material change, the Orders that were specific to this resident cannot be complied with by the Licensee.

The licensee has withdrawn the appeals.

Issued on this 21 day of September 2015 (A1)

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

Darlene Murphy

Original report signed by the Inspector.

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

DARLENE MURPHY (103) - (A1)

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

This Inspection was conducted on the following date(s): February 10-12, March 6, 9, 2015

During the course of the inspection, the inspector(s) spoke with the Resident, a Registered Practical Nurse (RPN), the Occupational Therapist (OT), Bariatric lift specialist for Shopper's Home Health Care, Manager South East Community Care Access Centre, representative from the Local Health Integration Network (LHIN), the home's two Director's of Care, the Administrator and the home's owner.

The inspector reviewed the resident health care record including the resident care plans, notes as provided by the Director of Care, and the bariatric lift specialist correspondence.

The following Inspection Protocols were used during this inspection:

Admission and Discharge

Dignity, Choice and Privacy

Personal Support Services

During the course of this inspection, Non-Compliances were issued.

2 WN(s)
0 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 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. 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).

Findings/Faits saillants :

1. The licensee has failed to follow the legislated requirements for discharge, prior to discharging Resident #1.

Resident #1 was admitted to Arbour Heights on a specified date and a review of the resident health care record was completed. The plan of care indicated the resident was encouraged to achieve and maintain an identified goal weight. The resident's weight upon admission to the home was identified as well as the last recorded weight of the resident and varied by five kilograms.

On an identified date, the home ceased all resident transfers from the bed and the resident was bedridden until a safer means of transfer could be assessed by the Physiotherapist and the Occupational therapist.

According to the resident health care record, Resident #1 experienced a decline in health status and was transferred and subsequently admitted to the hospital. The following day, the Administrator, two Directors of Care and the owner had a meeting and a "decision to discharge related to inability to provide a sufficiently secure environment for safety of resident, as the governing regulations, was decided." The

home subsequently drafted and sent a discharge letter to the resident, the resident's Power of Attorney (POA), the charge nurse at the hospital, the hospital discharge planners and the Community Care Access Centre.

On an identified date, this inspector met with the Administrator and one of the DOC's in person and the owner by means of teleconferencing. According to the team, they had been attempting to find a more suitable home for this resident for several years. The DOC indicated the resident had sustained a significant change in condition and the home was no longer able to provide safe care to this resident.

The home stated over the past several years, they have attempted to find a more suitable home for Resident #1. In 2012, St. Mary's on the Lake (SMOL) was asked to assess the resident for admission but advised the resident did not meet the criteria for complex care. SMOL was more recently asked to reassess the resident and once again the home was advised this resident did not meet the criteria for complex care.

The home's owner stated the home looked at a possible transfer to a bariatric facility in Mississauga. According to the DOC, Resident #1 had done some research on his/her own in regards to this facility. She confirmed there had been no collaboration with CCAC in regards to this or any other alternative accommodations considered. The owner also stated she had been in touch with the Local Health Integration Network (LHIN) because of insufficient funding to support this resident's needs. To date, the owner stated the LHIN had not provided any solutions.

A telephone interview was done on an identified date with Carole Park, Manager for Client Services Placement, South East CCAC who stated there has been no discussion or collaboration with CCAC over the past year and a half in regards to any discharge plans for Resident #1.

A telephone interview was completed on an identified date with Jennifer Payton from the LHIN. She stated she received a voice mail message from the home approximately two months ago stating they could no longer provide care for this resident. Payton stated she returned a call to the home and left a message for the Administrator, but there had been no further direct discussion between Arbour Heights and the LHIN.

The home was asked why the resident was discharged within twenty four hours of being admitted to an acute care facility given that the resident was entitled to a thirty day medical leave and was admitted to hospital with a treatable illness. The home

stated they had reviewed the legislation related to discharge and it was their impression, the discharge letter had to be delivered as quickly as possible. The home stated they believed the resident was not suitable for long term care and felt they had no alternative but to discharge the resident.

On an identified date, the inspector met with the DOC that has been working most closely with Resident #1. The list of changes previously provided by the home that described the resident's change in status was discussed. The DOC stated the resident and staff safety around the transfers was the primary reason for discharge.

The requirements on the licensee before discharging a resident, O. Reg 79/10 s. 148 (1) and (2) were reviewed. The DOC confirmed the home had not collaborated with the appropriate placement co-ordinator to make alternative arrangements for the accommodation of Resident #1. In addition, the home, despite attempting to find alternative accommodations for Resident #1 did not provide the resident or the resident's substitute decision maker a written notice setting out a detailed explanation of the supporting facts until the discharge letter was sent the day following the resident's hospitalization.

According to the Administrator, she believed the resident had been actively involved in plans related to alternative accommodations, but Resident #1 did not wish to be transferred out of the home and was therefore not cooperative with any discharge plans made by the home.

Resident #1 was interviewed on an identified date by telephone. The resident stated the home had not advised him/her of their discharge plan prior to receiving the discharge letter. Resident #1 stated he/she was aware the two assessments had been completed for SMOL, but that he/she did not qualify for complex care. Additionally, Resident #1 recalled some discussion related to a bariatric facility in Mississauga, but there had been no recent communication or discharge planning related to this. The resident stated that on an identified date, the home decided he/she could no longer be safely transferred using the present lift equipment. The resident stated there had been no other plans for discharge discussed once he/she was deemed not eligible for complex care.

The resident's care plan in effect at the time of discharge indicated:

-"investigate alternative placement to accommodate resident care level",
-No anticipation for discharge at this time. [s. 148. (2)]

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Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been rescinded:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to ensure that supplies, equipment and devices are readily available in the home to meet the nursing and personal care needs of residents.

Resident #1 was admitted to Arbour Heights on an identified date and the resident health care record was reviewed.

Resident #1 was interviewed and stated that since an identified date, he/she has not been transferred out of bed and all of the personal care is provided by 2-3 staff while in bed. According to the resident, he/she has not had a shower in the past six months. The resident expressed concern he/she had bought their own bariatric commode/shower chair and then was only able to use it a very short time before the home stated it was not safe. The resident reported, heavy duty anti-tip wheels were installed to rectify their concerns but was still told he/she could not safely use it. The resident reports immense upset by being confined to bed and missing out on family activities.

Before the home ceased all transfers, Resident #1 was being transferred out of bed using a hoyer lift that has an identified weight capacity. According to the staff and management of the home, the transfers were deemed unsafe and provided this

inspector with minutes of the auditing tool used and applicable meetings.

The OT had made modifications to the wheelchair, but was unable to assess the success of the modifications because all transfers were discontinued. The notes indicated the DOC would explore additional means of transfer.

A bariatric lift consultant employed by Shoppers Home Health was contacted by the home and made a site visit to the home on an identified date. The consultant met the resident and was able to view the resident's room and an XY ceiling lift with an identified weight capacity was recommended.

On an identified date, this inspector met with the DOC and the Administrator who both stated the home could not proceed with the XY ceiling lift because the owner had made an inquiry with the architect and was advised the precast slabs were designed to take a ceiling weight of an identified weight and anything more would be considered unsafe.

This inspector spoke with the bariatric lift consultant by telephone on an identified date who provided information that it is usual practice for the installer to meet with the architect to complete a joint site inspection. The installer stated that until this site visit is made, it is unclear if the installation could go forward. The installer stated XY ceiling lifts have been installed into hollow core concrete and stated the specs could be forwarded to the architect to review. Additionally, the lift specialist stated that there are alternative ways of installing the ceiling lift by means of a floor installation in instances where an overhead install is not possible. The installer stated it would be necessary for a site visit to be made prior to any decisions being made. The bariatric lift specialist stated he had not had any further correspondence from the home related to installation. He further stated that with the proper equipment, bariatric residents can be safely transferred with two staff and that this resident's room size would not pose a problem.

The DOC and Administrator stated neither of them had any further conversations with the lift installer to assess any possibilities with the XY ceiling lift because the owner had stated it was not possible.

The DOC and Administrator were further interviewed to determine what, if any, steps had been taken in regards to assessing for the safe transfers of Resident #1 by any additional means. Both stated they had not attempted to meet with other LTC homes that currently are managing the care of bariatric residents, nor had any other bariatric

specialists been asked to assess this resident for possible strategies to meet this resident's transfer needs.

Both the DOC and Administrator felt that due to the resident's current weight, safe transfers and care could not be provided in the long term care setting.

Resident #1 was subsequently admitted to an acute care facility after being confined to bed for a period of approximately fourteen weeks [s. 44.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been rescinded:CO# 002

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Issued on this 21 day of September 2015 (A1)

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

Darlene Murphy

Original report signed by the Inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : DARLENE MURPHY (103) - (A1)

Inspection No. / No de l'inspection : 2015_396103_0013 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : O-001529-15 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Sep 21, 2015;(A1)

Licensee / Titulaire de permis :
2109577 ONTARIO LIMITED
195 Forum Drive, Unit 617, MISSISSAUGA, ON, L4Z-3M5

LTC Home / Foyer de SLD :
2109577 ONTARIO LIMITED O/A ARBOUR HEIGHTS
564 Tanner Drive, KINGSTON, ON, K7M-0C3

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Christine Sellery

To 2109577 ONTARIO LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

(A1)
The following Order has been rescinded:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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;

(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;

(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

(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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Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

(A1)
The following Order has been rescinded:

Order # / Ordre no :	Order Type / Genre d'ordre :
002	Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

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REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 21 day of September 2015 (A1)

Signature of Inspector / Signature de l'inspecteur : Darlene Murphy

Name of Inspector / Nom de l'inspecteur : DARLENE MURPHY

Service Area Office / Bureau régional de services : Ottawa