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
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St., 4th Floor
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347, rue Preston, 4iém étage
Ottawa ON K1S 3J4

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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
March 22, 24, and 29, 2011	2011_103_9634_17Mar134210	Other (Critical Incident) Log #O-000608

Licensee/Titulaire

2109577 Ontario Limited o/a Arbour Heights
1050 Wenleigh Court,
Mississauga, ON L5H 1M7
Phone # 905-278-6789
Fax # 905-271-3478

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

Arbour Heights
546 Tanner Drive, Kingston, ON
K7M 0C3
Fax# 613-544-1101

Name of Inspector(s)/Nom de l'inspecteur(s)
Darlene Murphy #103

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct an inspection in regards to an incident between two residents.

During the course of the inspection, the inspector spoke with, the Administrator, the Assistant Director of Care, the Director of Care, a Registered Practical Nurse, three Personal care providers, a physician, a resident.

During the course of the inspection, the inspector observed the care provided on the unit and reviewed two resident health records.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation
Responsive Behaviors
Critical Incident Response

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

4 WN's
3 VPC's
1 CO: CO # 001

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 O. Regs. 79/10 s.98
Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Findings:.

1. The appropriate police force was not notified at the time of the incident.

Compliance order #001 was faxed to the licensee on March 29, 2011

WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8 s.24 (1)
A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

Findings:

1. The Director of Care (DOC) received notification from the charge nurse of an alleged abuse between two residents.
2. This was not reported to the Director until four days later.

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure mandatory reports defined under LTCHA 2007, S.O. 2007, c.8, s.24 (1)(1-5) are reported in accordance with the legislative requirements, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O. Regs. 79/10 s.107 (1)
Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

Findings:

1. Arbour Heights was in an outbreak on March 7, 2011.
2. The Director was not immediately informed as in accordance with the legislation.

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure critical incidents reportable under O. Regs. 79/10 s.107(1) (1-6) are reported in accordance with the legislation, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8 s. 6 (1)
Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident

Findings:

1. A resident's health record review was done.
2. A psychogeriatric assessment was requested for identified behaviors; written recommendations were made as a result of the assessment, but not implemented for a period of ten days.
3. Staff was interviewed and was unable to identify a monitoring schedule for the resident or interventions for the behaviors; they reported interventions to date were ineffective.
4. The resident's care plan does not define the undesirable behaviors; there are no directions to staff to indicate a monitoring schedule; there have been no updates in response to the resident's ongoing behaviors to date.

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the resident's plan of care includes clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

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. April 1/11
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).

Ontario

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
Direction de l'amélioration de la performance et de la conformité

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

	☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public		
Name of Inspector:	Darlene Murphy	**Inspector ID #**	103
Log #:	O-000608		
Inspection Report #:	2011_103_9634_17Mar134210		
Type of Inspection:	Other (Critical Incident)		
Date of Inspection:	March 22, 24, 2011		
Licensee:	2109577 Ontario Limited o/a Arbour Heights 1050 Wenleigh Court, Mississauga, ON L5H 1M7 Phone# 905-278-6789 Fax# 905-271-3478		
LTC Home:	Arbour Heights 546 Tanner Drive, Kingston, ON K7M 0C3 Fax# 613-544-1101		
Name of Administrator:	David Clegg		

To Arbour Heights, you are hereby required to comply with the following order by the date set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(a)]
Pursuant to: The licensee has failed to comply with O. Reg. 79/10 s.98 Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.			
Order: The licensee will ensure the appropriate police force is notified of each suspected incident of abuse of a resident.			

Grounds:
1. The appropriate police force was not notified at the time of a suspected incident of abuse.

This order must be complied with:	Immediately

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 service for the Licensee.

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

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
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 group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Issued on this 29th day of March, 2011	
Signature of Inspector:	Darlene Murphy
Name of Inspector:	Darlene Murphy
Service Area Office:	Ottawa Service Area office