Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jan 31, Feb 1, 2, 6, 7, 8, 9, 2012	2012_035124_0006	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

LYNDA HAMILTON (124), PAUL MILLER (143)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with The Administrator, the two Assistant Directors of Care, Family and Community Coordinator, Administrative Assistant,the complainants and a former resident of the home.

During the course of the inspection, the inspector(s) reviewed resident business files, resident health care record, policies and procedures and the Director of Care's notes including email correspondence.

This inspection report relates to log numbers O-002783-11 and O-000087-12.

The following Inspection Protocols were used during this inspection:

Hospitalization and Death

Resident Charges

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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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. 146. When licensee shall discharge

Specifically failed to comply with the following subsections:

s. 146. (4) A licensee shall discharge a long-stay resident if,
(a) the resident is on a medical absence that exceeds 30 days;
(b) the resident is on a psychiatric absence that exceeds 60 days;
(c) the total length of the resident's vacation absences during the calendar year exceeds 21 days; or
(d) the long-term care home is being closed. O. Reg. 79/10, s. 146 (4).

Findings/Faits saillants :

1. The following findings are in respect of log # O-002783-11:
On or about November 18, 2011 a resident began a psychiatric absence. On December 5, 2011 the licensee discharged the resident.

The licensee has failed to comply with this requirement by indicating that a psychiatric absence had exceeded 60 days

and discharged the resident when in fact the resident psychiatric absence was only 17 days. Ontario Reg. 79/10 sec.146.(4)b

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following subsections:

s. 148. (1) Except in the case of a discharge due to a resident's death, every licensee of a long-term care home shall ensure that, before a resident is discharged, notice of the discharge is given to the resident, the resident's substitute decision-maker, if any, and to any other person either of them may direct,
(a) as far in advance of the discharge as possible; or
(b) if circumstances do not permit notice to be given before the discharge, as soon as possible after the discharge. O. Reg. 79/10, s. 148 (1).

Findings/Faits saillants :

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1.The following findings are in respect of log # O-002783-11:
On December 5, 2011 a resident was discharged from the Nursing Home. On December 9, 2011 the discharged resident received written notification which provided a detailed explanation of supporting facts justifying the licensee's decision to discharge the resident.

The licensee has failed to comply with the requirement to ensure that residents are informed as far in advance of discharge as possible. Ontario Reg. 79/10 sec. 148.(1)a (143)

Additional Required Actions:

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 that written notice is given to residents as far in advance of the discharge as possible, to be implemented voluntarily.

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/ LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

CORRECTED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 r. 107.	CO #901	2011_035124_0001	124
O.Reg 79/10 r. 114.	CO #901	2011_035124_0011	124

Issued on this 9th day of February, 2012

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

P Mellen / L Hamilton