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
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
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 9, 10, 11, 2012	2012_049143_0037	Critical Incident

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

PAUL MILLER (143)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with The Administrator, the Director of Nursing, Assistant Director of Nursing and a resident.

During the course of the inspection, the inspector(s) conducted two Critical Incident Inspection log #O-001417-12 and log #O-001418-12.
A review of the home's abuse policies and procedures, health care records and internal abuse investigation reports were completed.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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

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.) 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 LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following subsections:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

A family member reported to the Acting Director of Nursing care issues related to resident # 2. A Registered Practical Nurse (S105) reported that a Personal Care Provider (PCP) staff member S104 spoke to resident # 2 in baby talk. The family member reported that the staff member calls the resident "Hon or sweet heart". A critical incident report was submitted to the Ministry of Health and Long Term Care. The home reported that the immediate action to prevent the recurrence as Staff member (S104) was asked to leave the building until completion of the investigation.
Staff member S104 received a written warning related to abuse and neglect.
In discussions with the Administrator it was confirmed that the staff member had verbally abused the resident by using a form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well being, dignity or self worth.

Personal Care Provider #S104 transferred resident # 1 who is totally dependent upon staff to provide all activities of daily living outside to a balcony terrace. The resident remained outside approximately three hours. A Registered Practical Nurse (S106) documented that the resident had sustained second degree burns to face and arms requiring nursing intervention to relieve the discomfort. A Critical Incident Report was submitted to the Ministry of Health and Long Term Care. The Critical Incident Reported immediate actions taken to prevent recurrence was that S104 was suspended.
The Administrator confirmed that S104 had neglected the resident by not providing care,services or assistance required for the health, safety and well-being of resident # 1.
A review of the Critical Incident Reporting system, Arbour Heights case notes with the Ottawa Service Area Office as well as discussions with the Administrator and the Director of Nursing indicated that the licensee has failed to comply with the LTCHA sec. 23.(2) by not reporting to the Director the results of the home's abuse or neglect investigation.

Issued on this 15th day of October, 2012

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

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