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
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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
Nov 6, 7, 8, 2012	2012_038197_0033	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

JESSICA PATTISON (197)

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 Care, an Assistant Director of Care, a Registered Practical Nurse, Personal Care Providers, a resident and a resident's Power of Attorney.

During the course of the inspection, the inspector(s) reviewed a critical incident report, the home's internal investigation file and a resident's health care record.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

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 LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following subsections:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 22(1) in that they did not immediately forward a written complaint that they received concerning the care of a resident to the Director.

The Director of Care received a letter of complaint concerning the care of a resident by a staff member in the home.

A copy of this letter was not received by the Director as of November 7, 2012.

An interview with an Assistant Director of Care on November 7, 2012 confirmed that a copy of this complaint was not forwarded to the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 103. (2) The licensee shall comply with subsection (1) immediately upon completing the licensee's investigation into the complaint, or at an earlier date if required by the Director. O. Reg. 79/10, s. 103 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 103(2) in that they did not submit a written report documenting the response the licensee made to the complainant immediately upon completion of their investigation.

The Director of Care received a letter of complaint concerning the care of a resident by a staff member in the home. An investigation into the concern was commenced immediately.

The complaint was reported to the Ministry of Health and Long-Term Care via the Critical Incident System under LTCHA 2007, s.24 (1) 2 - Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The Assistant Director of Care (ADOC) stated that the results of the complaint investigation were shared with the complainant, but that a report documenting the response to the complainant was not submitted to the Director immediately upon completion of the investigation.

Issued on this 8th day of November, 2012

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

Jessica Pattin, RD