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 sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 8, 2016	2016_505103_0046	018449-16, 020443-16, 023779-16, 026842-16, 029377-16	Critical Incident System

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)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 31, 2016, November 1-3, 2016

The following intakes were included in this inspection: 018449-16 (medication), 020443-16 (alleged resident to resident abuse), 023779-16 (resident fall), 026842-16 (alleged resident to resident abuse), 029377-16 (alleged resident to resident abuse).

During the course of the inspection, the inspector(s) spoke with residents, Personal support workers (PSW), a Registered Practical Nurse (RPN), the Director of care and the Administrator.

During the course of the inspection, the inspector conducted a walking tour of the Breakwater unit, observed resident care, reviewed resident health care records and the home's drug destruction process for controlled substances.

The following Inspection Protocols were used during this inspection:
Medication
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
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:

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 :

1. The following finding relates to Logs #020443-16 and #029377-16:

The licensee has failed to report to the Director (MOHLTC) the results of an investigation into two incidents of alleged resident abuse.

On an identified date, the home submitted an incident report for an alleged resident to resident physical abuse involving residents #003 and #006 that resulted in an injury to resident #006. The report indicated resident #003's behaviours, medications and care plan would be assessed and long term actions would be based on these assessments.

On another identified date, the home submitted an incident report for an alleged resident to resident physical abuse involving residents #002 and #003 that resulted in injury to resident #003. The report indicated the physician would review resident #002's medications and that the home would assess the need to relocate resident #002 to prevent another incident.

The Director of Care was interviewed and indicated both incidents were investigated by the home, but the home had failed to report the results of the investigations to the Director (MOHLTC).

As of the date of this inspection, the results of the home's investigation into the above two incidents of alleged resident abuse had not been provided to the Director. [s. 23. (2)]

Issued on this 8th day of November, 2016

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

Original report signed by the inspector.