



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 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

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Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: Apr 13, 14, May 4, 5, 9, 10, 2011; 2011\_035124\_0001; 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)

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 Director of Care, the Assistant Director of Care, registered practical nurse (RPN) and Personal Care Providers (PCP).

During the course of the inspection, the inspector(s) reviewed the resident's health record, reviewed the following policies and procedures of the home: "Head Injury Protocol", "Diabetic Diet-NFS 04-02-30", "Outbreak Contingency Plan-INF-II-60" and "Falls Prevention Policy and Procedure". "Residents First: On the Road to Quality Improvement" was also reviewed.

The following Inspection Protocols were used in part or in whole during this inspection:

Critical Incident Response

Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

<b>Definitions</b>  WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	<b>Définitions</b>  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. 107. Reports re critical incidents**

Specifically failed to comply with the following subsections:

**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):**

1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding.
2. An unexpected or sudden death, including a death resulting from an accident or suicide.
3. A resident who is missing for three hours or more.
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

**Findings/Faits sayants :**

The Assistant Director of Care advised the inspector that she did not report the critical incident to the Ministry of Health and Long-Term Care.

**Additional Required Actions:**

*CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".*

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

Specifically failed to comply with the following subsections:

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**

- (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
- (b) is complied with. O. Reg. 79/10, s. 8 (1).

**Findings/Faits sayants :**

1. Under O.Regulation 79/10, s. 49 (2), Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.
2. The resident sustained a fall and the registered staff member documented that the resident was to be monitored using Head Injury Routine.
3. The staff did not comply with the home's Head Injury Protocol when assessing the resident post-fall.



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*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 all registered staff monitor residents in accordance with the home's Head Injury Protocol, to be implemented voluntarily.*

Issued on this 11th day of May, 2011

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

A handwritten signature in cursive script that reads "Lynda Hamilton".



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et  
des Soins de longue durée**

**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

**Ordre(s) de l'inspecteur**  
Aux termes de l'article 153 et/ou  
de l'article 154 de la *Loi de 2007 sur les foyers  
de soins de longue durée*, L.O. 2007, chap. 8

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

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<b>Name of Inspector (ID #) / Nom de l'inspecteur (No) :</b>	LYNDA HAMILTON (124)
<b>Inspection No. / No de l'inspection :</b>	2011_035124_0001
<b>Type of Inspection / Genre d'inspection:</b>	Complaint
<b>Date of Inspection / Date de l'inspection :</b>	Apr 13, 14, May 4, 5, 9, 10, 2011
<b>Licensee / Titulaire de permis :</b>	2109577 ONTARIO LIMITED 195 Forum Drive, Unit 617, MISSISSAUGA, ON, L4Z-3M5
<b>LTC Home / Foyer de SLD :</b>	2109577 ONTARIO LIMITED O/A ARBOUR HEIGHTS 564 Tanner Drive, KINGSTON, ON, K7M-0C3
<b>Name of Administrator / Nom de l'administratrice ou de l'administrateur :</b>	DAVID CLEGG

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To 2109577 ONTARIO LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et  
des Soins de longue durée**

**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

**Ordre(s) de l'inspecteur**  
Aux termes de l'article 153 et/ou  
de l'article 154 de la *Loi de 2007 sur les foyers  
de soins de longue durée*, L.O. 2007, chap. 8

**Order # /**

**Ordre no :** 901

**Order Type /**

**Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

O.Reg 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):

1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding.
2. An unexpected or sudden death, including a death resulting from an accident or suicide.
3. A resident who is missing for three hours or more.
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

**Order / Ordre :**

The licensee shall:

(a) inform the Director of the critical incident by submitting the report required under subsection (4).

Part (a) of this order must be complied with by April 18, 2011

(b) prepare, submit and implement a plan to ensure that the Director is immediately informed as required by O. Reg. 107 (1) followed by the report required under subsection (4). This plan will include an educational component for all those with the responsibility of informing the Director.

Part (b) of this order must be complied with by May 6, 2011.

The plan is to be submitted to Inspector, Lynda Hamilton, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 347 Preston Street, 4th Floor, Ottawa, ON K1S 3J4, Fax: 613-569-9670 by April 22, 2011.

**Grounds / Motifs :**

1. The Assistant Director of Care advised the inspector that she did not report the critical incident to the Ministry of Health and Long-Term Care.

(124)

**This order must be complied with by /**

**Vous devez vous conformer à cet ordre d'ici le :** Apr 18, 2011



Ministry of Health and  
Long-Term Care

Ministère de la Santé et  
des Soins de longue durée

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

Ordre(s) de l'inspecteur  
Aux termes de l'article 153 et/ou  
de l'article 154 de la *Loi de 2007 sur les foyers  
de soins de longue durée*, L.O. 2007, chap. 8

**REVIEW/APPEAL INFORMATION / RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL**

**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 services 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: 416-327-760

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 tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the

Director

Attention Registrar  
151 Bloor Street West  
9th Floor  
Toronto, ON  
M5S 2T5

c/o Appeals Clerk  
Performance Improvement and Compliance Branch  
55 St. Clair 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](http://www.hsarb.on.ca).

**Issued on this 14th day of April, 2011**

Signature of Inspector /  
Signature de l'inspecteur :

Name of Inspector /  
Nom de l'inspecteur :

LYNDA HAMILTON

Service Area Office /

Bureau régional de services : Ottawa Service Area Office