



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

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

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

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**Division de la responsabilisation et de la
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Direction de l'amélioration de la
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Report Date(s) / Date(s) du rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 12, 2014	2014_371193_0006	T-1372-14/7459-14	Complaint

Licensee/Titulaire de permis

**THE GOVERNING COUNCIL OF THE SALVATION ARMY IN CANADA
2 OVERLEA BLVD TORONTO ON M4H 1P4**

Long-Term Care Home/Foyer de soins de longue durée

**ISABEL AND ARTHUR MEIGHEN MANOR
155 MILLWOOD ROAD TORONTO ON M4S 1J6**

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

MONICA NOURI (193)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): November 3, 6, 21 and 24, 2014.

During the course of the inspection, the inspector(s) spoke with family member, the Executive Director (ED), Director of Care (DOC), social worker (SW) and registered staff.

Ad-hoc notes were used during this inspection.

During the course of this inspection, Non-Compliances were issued.

- 3 WN(s)**
- 0 VPC(s)**
- 0 CO(s)**
- 0 DR(s)**
- 0 WAO(s)**



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 91. Resident charges



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Specifically failed to comply with the following:

s. 91. (1) A licensee shall not charge a resident for anything, except in accordance with the following:

1. For basic accommodation, a resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).

2. For preferred accommodation, a resident shall not be charged more than can be charged for basic accommodation in accordance with paragraph 1 unless the preferred accommodation was provided under an agreement, in which case the resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).

3. For anything other than accommodation, a resident shall be charged only if it was provided under an agreement and shall not be charged more than the amount provided for in the regulations, or, if no amount is provided for, more than a reasonable amount. 2007, c. 8, s. 91 (1).

4. Despite paragraph 3, a resident shall not be charged for anything that the regulations provide is not to be charged for. 2007, c. 8, s. 91 (1).

Findings/Faits saillants :



1. The licensee failed to ensure that residents are not charged for anything that the regulations provide not to be charged for.

The licensee's admission contract provides that the licensee could charge the resident bed holding fees, which is a prohibited charge under the regulation. The home's admission contract states under article II – Resident's Responsibilities, subsection 2.8: "If hospitalization of the resident exceeds the number of approved days, the resident and /or the SDM may sign a consent to hold the bed at the facility. The resident co-payment charges plus the bed-holding fee will be required as payment to hold the bed at the facility as per MOHLTC bed-holding policy in this case;"

Interviews with the ED, DOC and SW confirmed the information in the admission contract is accurate and reflects current practice in the home.

Charging a resident bed holding fees is prohibited under clause 5 of s. 245(1) of O.Reg. 79/10. The Ministry's bed-holding policy is reflected in the Regulation and there is no other applicable policy on bed-holding. The Regulation stipulates that a licensee must discharge a resident if the resident exceeds a medical or psychiatric absence (see s. 146(4)(a) and (b) of the Regulation), the licensee is prohibited from charging a resident bed holding fees under clause 4 of s. 91(1) of the Act and clause 5 of s. 245(1) of the Regulation, and the licensee must inform the CCAC within 24 hours after a bed in the home is no longer occupied (see s. 186 of the Regulation). [s. 91. (1) 4.]

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:

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 O. Reg. 79/10, s. 148 (1).

(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 licensee failed to ensure that, before resident #1 was discharged, notice of the discharge was given to the resident, or to the resident's substitute decision-maker as far in advance of the discharge as possible.

Record review indicated the resident was admitted to the hospital for an identified medical condition in 2014. The allowed 30 days medical absence was exceeded and the resident remained under a hospital's care.

The licensee discharged the resident 14 days later, when a letter of discharge was sent to the resident's SDM.

The licensee had a mandatory obligation to discharge the resident if the resident exceeded the 30 day medical absence, so the licensee should have known exactly when that date would arrive and should have been, therefore, able to provide advanced notice of the discharge. Furthermore, if the licensee had provided advanced notice that included an explanation of the readmission category for prioritization once the resident was discharged from hospital, the resident's substitute decision-maker may not have taken the resident out of hospital against medical advice solely for the purposes of circumventing the discharge provisions in the regulations.

Record review, interview with the resident's SDM, the home's ED and DOC confirmed that the notice of the discharge was not given to the resident or the resident's SDM prior to the actual discharge. [s. 148. (1) (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 186. Duty to inform placement co-ordinator of vacancies

Every licensee of a long-term care home shall, within 24 hours after a bed in the home is no longer occupied, inform the appropriate placement co-ordinator of the following:

- 1. That the bed is no longer occupied.**
- 2. The class of accommodation of the bed.**
- 3. The class of the bed within the meaning of subsection 187 (18) of the Act.**
- 4. The date on which the bed will be available for occupation. O. Reg. 106/12, s. 1.**

Findings/Faits saillants :



1. The licensee failed to ensure that, within 24 hours after a bed in the home is no longer occupied, informs the appropriate placement co-ordinator about the vacancy.

Resident #1 was admitted to the hospital for an identified medical reason in 2014. The resident remained in the hospital for more than 30 days.

The licensee, is required by the s. 146. (4) of the Ont. Reg. 79/10 to discharge the resident when 30 days medical absence was exceeded. The bed was no longer occupied and the licensee was required to inform the appropriate placement co-ordinator about the availability of the bed within 24 hours.

Interviews with the ED and DOC indicated that the placement co-ordinator was contacted, however, not to inform about the availability of the bed, but to ask for advice. The SW confirmed that the vacant bed was posted after more than 24 hours of becoming available.

Record review indicated that the current home's admission contract states under article II- Resident's Responsibilities subsection 2.9 the following:

"If vacation/casual leave exceeds the number of approved days, the resident and /or the SDM may sign a consent to hold the bed at the facility."

This procedure put in place is not in compliance with s. 186. 1 of the O. Reg. 79/10 which states "Every licensee of a long-term care home shall, within 24 hours after a bed in the home is no longer occupied, inform the appropriate placement co-ordinator of the following:

1. That the bed is no longer occupied."

Interviews with the ED, DOC and SW confirmed the information in the admission contract as accurate and current practice of the home. [s. 186. 1.]

Issued on this 12th day of December, 2014

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

Monica Nouri

Original report signed by the inspector.