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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 27, 2018	2018_751649_0014	018471-18	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Westside
1145 Albion Road ETOBICOKE ON M9V 4J7

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

JULIEANN HING (649)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 23 and 24, 2018.

The purpose of the inspection was to conduct a complaint inspection related to log #018471-18, related to illegal discharge of a resident.

During the course of the inspection, the inspector(s) spoke with the home's Regional Director of Operations (RDO), Executive Director (ED), Director of Care (DOC), Director of Home and Community Care Placement at Central Local Health Integration Network (LHIN), Manager at Central West LHIN, and Placement Facilitator at Central West LHIN.

During the course of the inspection the inspector conducted interviews and reviewed resident health records.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Dignity, Choice and Privacy

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 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 O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried;
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident;
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct was kept informed and given an opportunity to participate in the discharge planning and that his or her wishes were taken into consideration; and
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC)

indicating resident #001 had been discharged from the home without written notice and a discharge plan. The resident was transferred to the hospital for further assessment related to escalating responsive behaviours. According to the complainant the hospital conducted an assessment and deemed the resident suitable for discharge back to the home. The home allegedly refused to take the resident back, and advised the hospital that the resident had been discharged from the home.

A review of the resident’s most recent written plan of care indicated a history of an identified responsive behaviour related to excessive use of an identified item.

In interviews with the Executive Director (ED) and Director of Care (DOC) stated that on an identified date, resident #001 was transferred to hospital for further assessment due to an identified responsive behaviour. The ED told the inspector they thought the resident might have excessively used the identified item at the time of the incident but was unable to say for sure. The ED further stated the reason why the home discharged the resident to the hospital was because of safety concerns.

Interview with Director of Home and Community Care Placement at the Central Local Health Integration Network (LHIN) told the inspector that the resident was assessed in the hospital's emergency department and they deemed the resident stable, with no further medical interventions required. Subsequent calls to the home indicated they were not going to accept the resident back. The Director stated the emergency department is not the appropriate place to discharge a resident to from a long-term care home; the resident would be occupying an acute care bed.

A discharge letter was delivered to the resident by the home's Regional Director of Operations (RDO) and the DOC while in hospital on an identified date, advising they have been discharged from the home. The RDO, ED, and DOC confirmed in an interview there had been no prior discussion with the resident about discharge plans, prior to their receipt of the above mentioned discharge letter. According to the home's RDO there had been a discussion between the home and hospital, and the hospital was advised by the home that they could not take the resident back due to safety concerns. They were considering to discharging the resident due to escalating responsive behaviours and excessive use of an identified item.

In an interview with the Placement Facilitator and their manager at the Central West Local Health Integration Network (LHIN), they confirmed there was no collaboration with the home regarding alternative arrangements for accommodation, or for placement of the

resident in another long-term care home. According to the Placement Facilitator they were informed by the home on an identified date, of the resident's transfer to hospital and on the next day of the resident's discharge. Prior to this, they had not discussed plans for the discharge of resident #001 or any other alternative arrangements for accommodation, care and secure environment. Further there was no communication with the placement Facilitator that indicated the home had made alternative accommodation arrangements for the resident before they were discharged, after being transferred to hospital for further assessment.

The above mentioned interviews demonstrate that resident #001 was discharged from the home without an opportunity to participate in discharge planning, and the resident was not given written notice of the home's plan to discharge them until an identified date, while in hospital . [s. 148. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, was fully respected and promoted.

A complaint was submitted to the MOHLTC indicating resident #001 had been discharged from the home without written notice and a discharge plan. The resident was transferred to the hospital for further assessment related to escalating responsive behaviours. According to the complainant the hospital conducted an assessment and deemed the resident suitable for discharge back to the home. The home allegedly refused to take the resident back, and advised the hospital that the resident had been discharged from the home.

A review of the resident's most recent written plan of care indicated a history of an identified responsive behaviours related to excessive use of an identified item.

Interviews with the ED and DOC indicated that the resident had an identified furnishing in their room that they used. The ED stated that the resident was not allowed to have an identified item, that they stored in the identified furnishing in their room. It should always be obtained from the nurse, according to the physician's orders.

On an identified date the ED told the resident that the identified furnishing was being removed from their room and the resident was not happy about it.

In an interview the ED confirmed they had not obtained the resident's permission prior to the removal of the identified furnishing from the resident's room. [s. 3. (1) 1.]

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 the resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, is fully respected and promoted, to be implemented voluntarily.

Issued on this 4th day of August, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIEANN HING (649)
Inspection No. / No de l'inspection :	2018_751649_0014
Log No. / No de registre :	018471-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 27, 2018
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4
LTC Home / Foyer de SLD :	Westside 1145 Albion Road, ETOBICOKE, ON, M9V-4J7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Stephanie Karapita

To Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried;
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident;
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Order / Ordre :

The licensee must be complaint with O. Reg. 79/10, s. 148 (2).

Specifically, the licensee must:
1. Re-admit resident #001 to the home
2. Take steps to ensure the home is in compliance with O. Reg. 79/10, s. 148 (2) before discharging the resident.

Grounds / Motifs :

1. The licensee has failed to ensure that before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried;
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation,

care and secure environment required by the resident;
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct was kept informed and given an opportunity to participate in the discharge planning and that his or her wishes were taken into consideration; and
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) indicating resident #001 had been discharged from the home without written notice and a discharge plan. The resident was transferred to the hospital for further assessment related to escalating responsive behaviours. According to the complainant the hospital conducted an assessment and deemed the resident suitable for discharge back to the home. The home allegedly refused to take the resident back, and advised the hospital that the resident had been discharged from the home.

A review of the resident's most recent written plan of care indicated a history of an identified responsive behaviour related to excessive use of an identified item.

In interviews with the Executive Director (ED) and Director of Care (DOC) stated that on an identified date, resident #001 was transferred to hospital for further assessment due to an identified responsive behaviour. The ED told the inspector they thought the resident might have excessively used the identified item at the time of the incident but was unable to say for sure. The ED further stated the reason why the home discharged the resident to the hospital was because of safety concerns.

Interview with Director of Home and Community Care Placement at the Central Local Health Integration Network (LHIN) told the inspector that the resident was assessed in the hospital's emergency department and they deemed the resident stable, with no further medical interventions required. Subsequent calls to the home indicated they were not going to accept the resident back. The Director stated the emergency department is not the appropriate place to discharge a resident to from a long-term care home; the resident would be occupying an acute care bed.

A discharge letter was delivered to the resident by the home's Regional Director of Operations (RDO) and the DOC while in hospital on an identified date, advising they have been discharged from the home. The RDO, ED, and DOC confirmed in an interview there had been no prior discussion with the resident about discharge plans, prior to their receipt of the above mentioned discharge letter. According to the home's RDO there had been a discussion between the home and hospital, and the hospital was advised by the home that they could not take the resident back due to safety concerns. They were considering to discharging the resident due to escalating responsive behaviours and excessive use of an identified item.

In an interview with the Placement Facilitator and their manager at the Central West Local Health Integration Network (LHIN), they confirmed there was no collaboration with the home regarding alternative arrangements for accommodation, or for placement of the resident in another long-term care home. According to the Placement Facilitator they were informed by the home on an identified date, of the resident's transfer to hospital and on the next day of the resident's discharge. Prior to this, they had not discussed plans for the discharge of resident #001 or any other alternative arrangements for accommodation, care and secure environment. Further there was no communication with the placement Facilitator that indicated the home had made alternative accommodation arrangements for the resident before they were discharged, after being transferred to hospital for further assessment.

The above mentioned interviews demonstrate that resident #001 was discharged from the home without an opportunity to participate in discharge planning, and the resident was not given written notice of the home's plan to discharge them until an identified date, while in hospital .

The severity of the issue was determined to be a level two, as there was minimal harm or potential for actual harm to the resident. The scope of the issue was identified as level one, isolated. The home had a level two history, as they had previous unrelated non-compliances. (649)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 03, 2018

REVIEW/APPEAL INFORMATION

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 27th day of July, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : JulieAnn Hing

Service Area Office / Bureau régional de services : Toronto Service Area Office