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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 8, 2019	2018_674610_0024	005838-17, 026104-17, 002314-18, 006791-18, 009378-18, 011396-18, 014302-18, 023554-18, 026398-18, 030615-18, 030913-18, 030988-18	Complaint

Licensee/Titulaire de permis

Henley Place Limited
200 Ronson Drive Suite 305 TORONTO ON M9W 5Z9

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

Henley Place
1961 Cedarhollow Boulevard LONDON ON N5X 0K2

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

NATALIE MORONEY (610), DONNA TIERNEY (569), HELENE DESABRAIS (615)

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): November 27, 28, 29, 30, and December 3, 4, 5, 6, 7, 2018

The following intakes were inspected concurrently while in the home completing these compliant inspection:
Log #026104-17 Inspection #2018_674610_0024 Complaint info-line IL-54102-LO, related to personal support services.
Log #026398-18 Inspection #2018_674610_0024 Complaint info-line IL-60415-LO, related to care concerns.
Log #002314-18 Inspection #2018_674610_0024 Complaint info-line IL-55252-LO, related to personal support services.
Log #005838-17 Inspection #2018_674610_0024 Complaint info-line IL-49871-LO, related to allegation of abuse and neglect.
Log #023554-18 Inspection #2018_674610_0024 related to allegation of abuse and neglect.
Log #006791-18 Inspection #2018_674610_0024 Complaint info-line IL-56330-LO, related to personal support services.
Log #011396-18 Inspection #2018_674610_0024 Complaint info-line IL-57148-LO, related to personal support services.
Log #014302-18 Inspection #2018_674610_0024 Complaint info-line IL-57483-LO, related to personal support services.
Log #023554-18 Inspection #2018_674610_0024 Complaint related to allegation of abuse and neglect.
Log #030913-18 Inspection #2018_674610_0024 Complaint info-line IL-61977-LO, related to personal support services.
Log #030988-18 Inspection #2018_674610_0024 Complaint info-line IL-61990-LO, related to skin and wound management.
Log #019934-18 Inspection #2018_674610_0024 Critical Incident System #3045-000031-18, related to falls prevention and management.
Log #025451-18 Inspection #2018_674610_0024 Critical Incident System #3045-000040-18, related to falls prevention and management.
Log #008453-18 Inspection #2018_674610_0024 Critical Incident System #3045-000023-18, related to prevention of abuse and neglect.
Log #009378-18 Inspection #2018_674610_0024,Critical Incident System #3045-000031-18, related to personal support service
Log #023851-18 Inspection #2018_674610_0025 Critical Incident System #3045-000036-18, related to medication management.
Log #024128-18 Inspection #2018_674610_0025 Critical Incident System #3045-000035-18, related to medication management.
Log #007501-18 Inspection #2018_674610_0025 Critical Incident System #3045-000011-18, related to infection prevention and control.

Log #006498-18 Inspection #2018_674610_0025 Critical Incident System #3045-000007-18, related to infection prevention and control.
Log #019842-18 Inspection #2018_674610_0025 Critical Incident System #3045-000030-18, related to responsive behaviours

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Associate Director of Care(s), Registered Nurses, Registered Practical Nurses, Personal Support Workers, Behavioural Supports Ontario (BSO), Director of Clinical Services, Physiotherapist, Social Worker, Registered Dietitians, family members and resident's.

The inspector(s) also made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) medication storage areas, resident/staff interactions, infection prevention and control practices, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **3 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	Légende 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A) The Ministry of Health and Long Term Care (MOHLTC) received a complaint. The complaint issued was related to various care concerns for an identified resident One care concern in particular was related to the resident's altered skin integrity issues.

A review of the identified resident's record of documentation showed that they had

altered skin integrity to an identified area.

In an interview with a nurse, they affirmed that the resident currently had two areas of altered skin integrity and they disclosed that weekly wound assessments were captured on a paper document. The nurse was asked if there should have been ongoing weekly wound assessments for the altered skin integrity. They said that they would have done ongoing separate wound assessments but perhaps the other nurses assessed both identified areas together and documented only under one assessment.

The ADOC was asked if there should be one or two separate wound assessments for both areas. They responded that because there were multiple regions that they were not separate from each other and one weekly wound assessment wound include the entire area.

The licensee's Care Planning Policy, stated in part that the "residents plan of care is to reflect the current needs of the resident. The care plan is to be kept current" and the registered staff are "to ensure that the plan of care provides clear direction".

The ADOC said the documentation appeared confusing but the weekly wound assessments were completed on identified dates and could have been for both areas of skin altercations and further acknowledged that the direction to staff related to assessing and documenting the identified resident's were not clear.

B) The Ministry of Health and Long Term Care (MOHLTC) received a complaint for an identified resident related to care concerns.

A review of complaint stated in part that the family was concerned about the identified resident's safety risks, care and well being in the home. The complainant had requested only specific care providers for the identified resident, as well as treatments, and personal support service care. Complainant stated they tried to address the issues with ADOC on several attempts and did not feel that the care concerns had been addressed.

Review of record documentation completed by the ADOC showed that the SDM had requested specific care providers for the resident and the ADOC documented that the care plan was updated and the staff would be made aware and had not.

A review of the plan of care for the resident showed that the plan of care regarding only specific staff for care was not updated until approximately five months after the request

was received to the ADOC.

The resident had been observed on a specific date with mood concerns and altered skin condition on identified area's after receiving care. A PSW stated that they had provided care to the resident that day and was not aware that only specific staff were provide care to the resident.

The ADOC acknowledged that although triggers were developed for the resident, and were made aware of the concerns with certain staff providing care the home still provided the care providers that should not have been providing care.

The Administrator said that the homes expectation was that clear direction would be provided to staff and that care would be provided as specified in the plan of care.

The licensee has failed to ensure that there was a written plan of care for the identified resident and that the plan of care provided clear directions to staff and others who provided direct care to the resident.

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated, consistent with and complemented each other.

A) The Registered Dietician documentation showed that on a specific date they had received a nutritional referral for a specific resident, and a nutritional intervention would be changed . Further review of the physician orders showed that there was no documented evidence that the resident's diet changes had been ordered.The Food Service Supervisor revised the plan of care for the resident as well with the incorrect nutritional intervention.

Review of the record documentation completed by the Registered Dietician showed that a specific resident was to receive a new nutritional intervention.

The licensee's Dietary Nutrition Monitoring Policy, stated in part that "any changes needed based on risk level and individual dietary needs of the resident will be recorded/updated as soon as the risk or change in status is identified".

The RD stated that they did not create an order on a specific date and should have for a

nutritional intervention and that they did not document the correct change of nutritional intervention into the plan of care. The RD also stated that the orders, were not updated into resident plan of care to reflect the correct nutritional interventions.

Further record review showed that the resident's assessment was completed on an identified date, however there was no documented evidence of the nutritional risk plan of care for the identified resident. Documentation also showed that the resident was not meeting the nutritional intake and was at risk.

The licensee's Hydration Monitoring Policy stated in part, "when a resident's fluid intake is below 1000 mls in a day, the registered staff will document this on the 24 hour report and the PSW's will be informed which residents require extra encouragement with the fluids the next day. A progress note will be entered in PCC" and if "a resident's fluid intake is less than 1000 mls in a day a progress note is entered in PCC by the registered staff for the resident" and a "referral would be made to the Registered Dietician (RD) and the Food and Nutritional Manager/Food Service Supervisor using the PCC Nutrition referral". For the Care Plan the RD "will document individualized fluid requirements for each resident and any individualized interventions specific to the resident's hydration needs".

Record review of documentation showed that there was no documented evidence that suggested a referral was sent to the RD related to the nutritional risk for the resident.

B) A review of a specific resident's record documentation showed the current active nutritional interventions were incorrect.

The licensee's Dietary Nutrition Monitoring Policy, stated in part that "any changes needed based on risk level and individual dietary needs of the resident will be recorded/updated as soon as the risk or change in status is identified".

The RD stated that they they are responsible for completing the care plan and updating the plan of care when there are changes related to nutritional interventions.

The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated, consistent with and complemented each other. [s. 6. (4) (b)]

3. The licensee has failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan.

A) The Ministry of Health and Long Term Care (MOHLTC) received three complaints on identified dates related to three specific residents and their individualized plan of care not being followed.

The ADOC stated that the SDMs for the three residents had not been provided the opportunity to participate fully in the development and implementation of the plan of care.

Record documentation showed that the three identified residents had routines set out in the plan of care but were not being followed related to a communication note that was provided from the ADOC to the staff that would be providing care to the identified residents.

The Administrator acknowledge that the expectation would be that the plan of care would be followed as specified for routines. [s. 6. (7)]

4. The licensee has failed to ensure that when a resident was reassessed and the plan of care was being revised because care set out in the plan has not been effective, different approaches were considered in the revision of the plan of care.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint related to a specific resident related to care concerns.

A review of complaint stated in part that they had concerns for a specific resident's safety risks. Complainant stated they tried to address the issues with the ADOC several times and did not feel that the care concerns had been addressed

The licensee's Care Planning Policy stated in part that the "residents plan of care is to reflect the current needs of the resident. The care plan is to be kept current" and the registered staff "is to ensure that the plan of care provides clear direction". The resident/family and Substitute Decision Maker (SDM) "is to be involved in the care planning process".

The licensee's Falls Policy, stated in part that interventions to be included in the preventative strategies in the care plan based on the individualized resident assessment

included but not limited to "devices to reduce risk of falls, ie chair/bed alarm, hi/low, raised toilet seats" and registered staff completing the tool will revise the "resident's plan of care" if required.

The record documentation was reviewed and showed that the specific resident was at moderate risk and intervention were in place and was independent with mobility.

Review of record documentation was reviewed and showed that the resident risk level increased and new intervention would be put in place.

The record review of documentation in the plan of care showed showed different levels of mobility and required mobility aids.

During an interview the ADOC said that the home had not trialed intervention that would have helped alert staff of the resident's movement. The ADOC further said that the required actions discussed had not been implemented in to the plan of care and that the resident increase to high risk were also not implemented in the plan of care.

The Director of Clinical Care Services said that the mobility aide was not specified in the plan of care for the resident.

The licensee has failed to ensure that when a resident was reassessed and the plan of care was being revised because care set out in the plan has not been effective, different approaches were considered in the revision of the plan of care. [s. 6. (11) (b)]

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provided direct care to the resident, and to ensure that staff and others involved in the different aspects of care collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated, consistent with and complemented each other, and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, and to ensure that when a resident is reassessed and the plan of care is being revised because care set out in the plan has not been effective, different approaches were considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint related to various care concerns for an identified resident.

Review of record documentation indicated that on a specific date family approached the registered staff with concerns that a specific resident did not look well and was in discomfort. The family wanted to have the resident's medication increased to help with the discomfort. The physician was notified but no changes were made to the assessments on a specific date.

The Physician's documentation, indicated that resident was unwell and had a significant change in status the resident had been discharged to hospital.

The home's pain policy number 04-27 with a revision date of December 2015, stated that "Residents who express new pain or an exacerbation of existing pain will have a pain assessment completed at the time of pain expressions."

Review of documentation showed there was no documentation present that showed an assessment had been completed by staff after the concern was received that the resident was in discomfort.

The ADOC who was also the program lead, said that when a resident expressed discomfort the home should have completed an assessment. They acknowledged that the was not completed for the specific resident.

The licensee failed to ensure that resident's discomfort that was identified by their family, was assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

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 when a resident's pain is not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

A) The Ministry of Health and Long Term Care (MOHLTC) received a complaint for a

specific resident's, regarding safety risks and concerns.

The complainant had requested an intervention that would alert the staff to help decrease the resident's safety risk.

A review of the home's policy "Complaints" stated in part "The Home will respond to complaints whether they are written or verbal in a timely manner. Verbal complaints that can be resolved within 24 hours do not require a written record of the complaint as well as the investigation and outcome will be retained by the Home. All verbal complaints will be entered on the Complaint Log".

A review of the resident's record documentation showed that there was several safety risks that could lead to injury that had not been addressed with the interventions requested by the complainant.

A review of the home's complaint logs did not include the complainant's complaints or concerns.

During an interview, the ADOC stated that they were involved with the complainants concerns and did not have complaint training and said that they were unaware with the home's policy for dealing with complaints and had not completed the complaint/concerns process. The ADOC added that the staff should have brought the concerns to management.

During an interview, the DOC said that the complainant's concerns should have been escalated and that the process with dealing with complaints/concerns was not followed and no documentation was initiated and kept in the home.

During an interview, the Administrator stated that when residents or family approached them with concerns that they wrote everything down in the complaint log binder and treated as a complaint, all the time.

B) The Ministry of Health and Long Term Care (MOHLTC) received a complaint related to a specific resident's regarding care concerns.

Record review on specific dates showed that the complaint/concerns for a specific resident were related to a treatment that the resident required and that the concern had gone unaddressed by the home.

A review of the home's complaint log binder showed that the home did not include the complainant's complaints or concerns.

During an interview, the Administrator stated that when residents or family approached them with concerns that they wrote everything down in the complaint log binder. [s. 101. (2)]

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 a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A) Critical Incident System report was submitted to the Ministry of Health and Long-Term

Care (MOHLTC) regarding allegations of abuse from staff to a specific resident.

A review of the resident's documentation record showed that the allegations of abuse had occurred on a specific date, and there was no documented evidence that the nurse had reported the abuse to the home's management team.

A review of the licensee's "Zero Tolerance of Resident Abuse/ Neglect" policy #06-02 last reviewed on September 2010, stated in part "in any case of abuse/neglect or suspected abuse, the employee, student, volunteer, or any other person that witnesses or has knowledge of the incident shall, immediately report the incident" and the Administrator will "submit a written report to the MOHLTC with the description of the individual's involved in the incident".

The Administrator had reviewed CIS report and internal investigation notes and stated that they did not write the description of the staff involved in the incident on the CIS report. Record documentation revealed that the nurse had not reported the incident to management.

B) The home submitted Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) regarding allegations of abuse from staff to a specific resident.

A review of the home's internal investigation notes showed that the Social Worker became aware of the allegations, however further review showed that the Social Worker had emailed management to notify them of the incident, and was not immediately report.

The Social Worker told inspector (s) that they should have immediately reported the concern to the manager in the building or the on call manager and had not.

The Administrator said the homes expectation was that staff immediately reported any allegation of abuse/neglect and Social Worker and had not.

The licensee failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. In making a report to the Director under subsection 23 (2) of the Act, the licensee has failed to include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: ii. names of any staff members or other persons who were present at or discovered the incident.

The home submitted Critical Incident System (CIS) to the Ministry of Health and Long-Term Care (MOHLTC) regarding allegations of abuse from staff to a specific resident.

Review of the CIS report showed that the names of staff members or other persons who were present or discovered the incident were not included on the CIS report to the Director.

Record review of the home's internal investigation documentation showed that the staff had been present at the time the incident that had occurred to the specific resident.

B) The home submitted CIS report to the Ministry of Health and Long-Term Care (MOHLTC) regarding allegations of abuse.

A review of a specific resident's documentation record showed that the allegations of abuse had occurred on a specific date.

Review of the CIS report showed that the names of staff members or other persons who were present or discovered the incident were not included on the CIS report to the Director.

Record review of the home's internal investigation documentation showed that staff had been present at the time the incident that had occurred to the resident.

The Administrator #101 confirmed that the staff names who were present should have been on the CIS report to the director and were not. [s. 104. (1) 2. ii.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 245. Non-allowable resident charges
The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.
2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.
3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.
4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.
5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.
6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.
7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.
8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

1. The following charges were prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act: 3. Charges for goods and services that the licensee was required to

provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network.

The licensee has failed to ensure that goods and services were provided to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint related to a specific resident's family financial charged for an intervention device for safety for the resident.

A review of complaint stated in part that the family was concerned about the resident's safety. The complainant had requested an intervention that would decrease the risk of injury and alert staff of safety needs. The complainant stated the Assistant Director of Care said the cost of the device would need to be paid by the family. The complainant said they were upset and stated that this equipment should be covered by the home.

A review of the Government of Ontario "Falls Prevention Equipment Funding Policy" :

"1.0 Purpose of Funding: To provide supplementary funding to Long-Term Care (LTC) homes to procure equipment, (including devices and assistive aids) that will help prevent residents from falling or suffering injuries from falls";

"2.0 Funding Approach: All Licensees that are party to a Letter of Agreement for Ministry Direct Funding to Long-Term Care Homes (DFA) with the Ministry of Health and Long-Term Care (ministry) with respect of a LTC home will receive direct Falls Prevention Equipment Funding from the ministry for the LTC home, in accordance with, and subject to, the terms and conditions of this policy and the DFA";

"3.2 Subject to sections 3.0, and 3.3, the Funding may be expended on one or more of the following personal falls or injury prevention equipment (including devices and assistive aids) 3.2.5 Alarms (e.g. seat belt alarms; seat pad alarms; bed alarms; chair alarms; toilet seat alarms)."

During an interview, the DOC and ADOC both stated that they were unaware that this equipment was to be paid for by the home.

During an interview, the Administrator stated that the home should have paid for the

resident 's device and that the family would be reimbursed. [s. 245. 3.]

Issued on this 14th day of January, 2019

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

Original report signed by the inspector.