Ontario

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 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
Oct 30, 2019	2019_798738_0021	011733-19, 011734-19, 011735-19, 011736-19, 017932-19, 018000-19, 018017-19, 018224-19	Follow up

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Halton Hills
9 Lindsay Court Georgetown ON L7G 6G9

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

AMANDA OWEN (738), AMANDA COULTER (694)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): October 15-18 and 21-22, 2019. Tawnie Urbanski, Inspector #754 was also present during inspection.

The following intakes were completed in this Follow up inspection:

Log #011733-19, Follow up to Compliance Order (CO) #001 from inspection #2019_723606_0006 related to minimizing the risk of altercations and potentially harmful interactions; Log #011735-19, Follow up to CO #002 from inspection #2019_723606_0006 related to registered nurse staffing; Log #011736-19, Follow up to CO # 003 from inspection #2019_723606_0006 related to reporting certain matters to the Director; and Log #011734-19, Follow up to CO #001 from inspection #2019_723606_0007 related to prevention of abuse and neglect.

The following Critical Incident System (CIS) intakes were also completed during this Follow up inspection: Log #018000-19/CIS #2892-000030-19 related to falls prevention and management; Log #018017-19/CIS #2892-000031-19 related to responsive behaviours; and Log #017932-19/CIS #2892-000032-19 related to an incident with injury.

The following Complaint intake was also completed during this Follow up inspection: Log # 018224-19 related to resident care concerns.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Administrator, Director of Care (DOC), DOC Clerk, Nutrition Manager, Registered Dietician, Behavioural Support Ontario (BSO) Lead, Registered Practical Nurses (RPN), Personal Support Workers (PSW) and Dietary Aide.

The inspector(s) also toured the home, observed resident care provision, reviewed residents' clinical records and relevant internal records.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Sufficient Staffing

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2019_723606_0007	738
LTCHA, 2007 S.O. 2007, c.8 s. 24.	CO #003	2019_723606_0006	738
O.Reg 79/10 s. 54.	CO #001	2019_723606_0006	738

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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse (RN) who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

This inspection was completed as a Follow up to CO #002 from inspection #2019_723606_0006, related to 24-hour RN coverage.

The home's daily staffing compliment for the nursing department was reviewed for the period of September 9, 2019 to October 15, 2019. It showed that the home had scheduled a RN from A-Supreme Nursing Agency to be in charge of the building on the following dates: Oct 9, 2019 (day shift); September 9, 10, 11, 13, 14, 15, 17, 25 and October 5, 6, 10, 14, 2019 (evening shift); and September 14, 2019 (night shift).

The DOC Clerk, who was responsible for staffing the nursing department, and DOC #103 acknowledged that the home had scheduled agency RNs to be in charge of the building on the dates outlined above and there were no other RNs working in the home at the time.

The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations. [s. 8. (3)]

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. 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 without restricting the generality of the duty provided for in section 19, that a written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's policy titled Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, dated June 2019, showed that any employee who becomes aware of an alleged, suspected or witnessed resident incident of abuse would report it immediately to the administrator/designate/reporting manager or if unavailable, to the most senior supervisor on shift at that time.

A) CIS Report #2892-000033-19 documented that on a specified date and time, PSW #112 observed an agency staff slap resident #006 on the back. PSW #112 did not report the incident of alleged abuse until the following day.

PSW #112 stated that they considered the incident to be abuse. They said they did not report the incident until the following day because it was late, they were busy and had forgotten. They said they should have reported the incident immediately.

B) CIS Report #2892-000029-19 documented that on a specified date and time, resident #013 complained to a RPN that they had been rough handled by a PSW. The incident was not reported to management until several days later, when it was identified in the progress notes by a RN.

Assistant Administrator #117 confirmed this and said that the home's procedure would have been for the RPN to report the incident to the RN and for the RN to report it to management.

C) A complaint was submitted to the Ministry of Long Term Care (MLTC). It documented that on a specified date and time, the complainant was visiting resident #002 when they

said, "they are hitting me". The complainant reported the resident's comments to a RPN at that time.

DOC #103 said the RPN did not report the incident to management. They said management became aware of the incident through reading about it in the progress notes.

The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with for residents #006, #013 and #002 in relation to reporting. [s. 20. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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 licensee has failed to ensure that a resident was not charged for goods and services that the licensee was required to provide under any agreement between the licensee and ministry or between the licensee and the Local Health Integration Network (LHIN).

Resident #002, #007 and #012 were assessed and determined to be a high risk for falls. Staff of the home discussed with the residents' Substitute Decision Makers (SDM) the use of specified devices to mitigate the risk of injury should they fall and suggested they purchase the devices.

During a Follow up inspection, when staff were interviewed regarding the use and availability of falls and injury prevention equipment in the home, RPN #114, RPN #115, RPN #117 and PSW #108, each stated that the devices were purchased and provided by the family members. DOC #103 confirmed this and said the home would initially ask family members to purchase the specified devices, but if they were not willing, then the home had extra in stock they could provide.

The licensee has failed to ensure that residents #002, #007 and #012 were not charged for goods and services that the licensee was required to provide residents using funding that the licensee received from the LHIN and/or the ministry for falls prevention and management. [s. 245. 1.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were provided with food and fluids that were safe.

A complaint was submitted to the MLTC, that alleged resident #002 had been fed improper foods by staff.

Inspector #754 completed dining observations during the lunch meal service on October 15 and 16, 2019. They observed staff feed resident #002 specified food products.

A review of resident #002's care plan showed they were not to receive the specified food products they had been fed during the lunch meal service. The foods were not the texture or consistency that the resident required to ensure safe swallowing.

Nutrition Manager #106 said the specified items that resident #002 received during the lunch meal service should not have been provided to them. Registered Dietician #110 said staff should have followed resident #002's care plan.

The licensee has failed to ensure that resident #002 was provided with food and fluids that were safe. [s. 11. (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 resident #002 is provided with food and fluids that are safe, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
8. Diet orders, including food texture, fluid consistencies and food restrictions. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a 24-hour admission care plan was developed for each resident and included the following: diet orders, including food texture, fluid consistencies and food restrictions.

A review of the 24-hour admission care plan and resident details report provided by DOC #103 was completed for resident #002. The report showed that a diet order, including food texture, fluid consistencies and food restrictions was not created for them until several days after they were admitted to the home.

DOC #103 said that they could not locate documentation to show that a 24-hour admission care plan with diet orders had been created for resident #002 within 24 hours of them being admitted to the home. They said that they looked for these diet orders with Nutrition Manager #106 and Registered Dietician #110.

The licensee has failed to ensure that a 24-hour admission care plan was developed for resident #002 and included the following: diet orders, including food texture, fluid consistencies and food restrictions. [s. 24. (2) 8.]

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 24-hour admission care plans are developed for each resident and include the following: diet orders, including food texture, fluid consistencies and food restrictions within 24-hours of them being admitted to the home, to be implemented voluntarily.

WN #6: 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to residents as specified in the plan.

A complaint was submitted to the MLTC, that alleged resident #002 had been fed improper food products.

Inspector #754 completed dining observations during the lunch meal service on October 15 and 16, 2019. They observed staff feed resident #002 specified food products.

A review of resident #002's care plan showed they were not to receive the specified food products they had been fed during the lunch meal service.

Nutrition Manager #106 confirmed that resident #002 should not have been the specified food products. They said that the home had developed a pre-select menu that reflected the resident's diet preferences.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan. [s. 6. (7)]

Issued on this 12th day of November, 2019

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

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

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) :	AMANDA OWEN (738), AMANDA COULTER (694)
Inspection No. / No de l'inspection :	2019_798738_0021
Log No. / No de registre :	011733-19, 011734-19, 011735-19, 011736-19, 017932-19, 018000-19, 018017-19, 018224-19
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Oct 30, 2019
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Halton Hills 9 Lindsay Court, Georgetown, ON, L7G-6G9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Emily Bosma

Ontario

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

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

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 : 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_723606_0006, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee must be compliant with s. 8. (3) of the Long Term Care Homes Act (LTCHA), 2007.

Specifically the licensee must:
a) Ensure that at least one registered nurse (RN) who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations; and
b) Track RN vacancies and recruitment strategies implemented and ensure documentation is maintained in the home.

Grounds / Motifs :

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

1. 1. The licensee has failed to ensure that at least one registered nurse (RN) who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

This inspection was completed as a Follow up to CO #002 from inspection #2019_723606_0006, related to 24-hour RN coverage.

The home's daily staffing compliment for the nursing department was reviewed for the period of September 9, 2019 to October 15, 2019. It showed that the home had scheduled a RN from A-Supreme Nursing Agency to be in charge of the building on the following dates: Oct 9, 2019 (day shift); September 9, 10, 11, 13, 14, 15, 17, 25 and October 5, 6, 10, 14, 2019 (evening shift); and September 14, 2019 (night shift).

The DOC Clerk, who was responsible for staffing the nursing department, and DOC #103 acknowledged that the home had scheduled agency RNs to be in charge of the building on the dates outlined above and there were no other RNs working in the home at the time.

The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

The severity of this issue was determined to be a level 1 as there was no harm. The scope of the issue was a level 3 as it affected all of the residents in the home. The home had a level 4 compliance history that included:
- CO issued on June 7, 2019 (2019_723606_0006). (738)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 27, 2020

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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 : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 20. (1) of the LTCHA, 2007.

Specifically the licensee must:
a) Comply with the home's Zero Tolerance of Resident Abuse and Neglect policy and related procedures for reporting incidents of alleged, suspected or witnessed abuse or neglect; and
b) Ensure that each staff member hired by the home and any agency staff member working in the home receive training of the home's reporting process as outlined in their policy and there is documentation to support this training.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that without restricting the generality of the duty provided for in section 19, that a written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's policy titled Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, dated June 2019, showed that any employee who becomes aware of an alleged, suspected or witnessed resident incident of abuse would report it immediately to the administrator/designate/reporting manager or if unavailable, to the most senior supervisor on shift at that time.

A) CIS Report #2892-000033-19 documented that on a specified date and time, PSW #112 observed an agency staff slap resident #006 on the back. PSW #112 did not report the incident of alleged abuse until the following day.

PSW #112 stated that they considered the incident to be abuse. They said they did not report the incident until the following day because it was late, they were busy and had forgotten. They said they should have reported the incident immediately.

B) CIS Report #2892-000029-19 documented that on a specified date and time, resident #013 complained to a RPN that they had been rough handled by a PSW. The incident was not reported to management until several days later, when it was identified in the progress notes by a RN.

Assistant Administrator #117 confirmed this and said that the home's procedure would have been for the RPN to report the incident to the RN and for the RN to report it to management.

C) A complaint was submitted to the Ministry of Long Term Care (MLTC). It documented that on a specified date and time, the complainant was visiting resident #002 when they said, "they are hitting me". The complainant reported the resident's comments to a RPN at that time.

DOC #103 said the RPN did not report the incident to management. They said management became aware of the incident through reading about it in the progress notes.

The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with for residents #006, #013 and #002 in relation to reporting.

The severity of this issue was determined to be a level 1 as there was no harm. The scope of the issue was a level 3 as it affected three out of three resident incidents reviewed. The home had a level 3 compliance history that included:
- VPC issued on August 8, 2017 (2017_482640_0013); and
- VPC issued on March 19, 2019 (2019_723606_0006). (738)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 27, 2020

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

Ministère 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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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 : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 245. 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.

Order / Ordre :

The licensee must be compliant with s. 245. of the Ontario Regulations 79/10.

Specifically the licensee must ensure that residents are not charged for falls prevention equipment that the licensee was required to provide to the residents using funding that the licensee received from the Local Health Integration Network (LHIN) or accommodation charges received under the LTCHA.

The licensee must ensure:
a) The LTCH stops charging residents #002, #007 and #012 and any other resident requiring falls prevention equipment.
b) Residents/Substitute Decision Makers (SDM) are made aware of the falls prevention equipment available to them at no cost; and
c) An audit is conducted of all residents who lived in the home during 2019 to determine if they had used or are using falls prevention equipment that was provided by the resident/representative. The licensee shall reimburse all expenses incurred by the resident/representative in 2019, for the full cost of the equipment used.

Grounds / Motifs :

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

1. 1. The licensee has failed to ensure that a resident was not charged for goods and services that the licensee was required to provide under any agreement between the licensee and ministry or between the licensee and the Local Health Integration Network (LHIN).

Resident #002, #007 and #012 were assessed and determined to be a high risk for falls. Staff of the home discussed with the residents' Substitute Decision Makers (SDM) the use of specified devices to mitigate the risk of injury should they fall and suggested they purchase the devices.

During a Follow up inspection, when staff were interviewed regarding the use and availability of falls and injury prevention equipment in the home, RPN #114, RPN #115, RPN #117 and PSW #108, each stated that the devices were purchased and provided by the family members. DOC #103 confirmed this and said the home would initially ask family members to purchase the specified devices, but if they were not willing, then the home had extra in stock they could provide.

The licensee has failed to ensure that residents #002, #007 and #012 were not charged for goods and services that the licensee was required to provide residents using funding that the licensee received from the LHIN and/or the ministry for falls prevention and management.

The severity of this issue was determined to be a level 1 as there was no harm. The scope of the issue was a level 3 as it affected three out of three residents reviewed. The home had a level 2 compliance history that included more than one non-compliance, none of which were related to the same subsection being cited. (694)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 27, 2020

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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 30th day of October, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amanda Owen

Service Area Office /
Bureau régional de services : Central West Service Area Office