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 sions de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
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159 rue Cedar Bureau 403
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 24, 2016	2016_281542_0008	003284-16	Complaint

Licensee/Titulaire de permis

The Corporation of the City of Timmins
481 Melrose Blvd. TIMMINS ON P4N 5H3

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

GOLDEN MANOR
481 MELROSE BOULEVARD TIMMINS ON P4N 5H3

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

JENNIFER LAURICELLA (542)

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): February 29, 2016, March 1 and 2, 2016.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, the Director of Nursing, Medical Director, Primary Care Physician, Behavioural Supports Ontario staff, Community Care Access Centre (CCAC) and the resident's family member.

The following Inspection Protocols were used during this inspection:
Admission and Discharge

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

2 WN(s)
0 VPC(s)
2 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. Before the licensee purported to discharge resident #001 under subsection 145 (1), the licensee failed to (a) consider alternatives to discharge and where appropriate, try alternatives, (b) collaborate with the appropriate placement co-ordinator and other health service organizations and make alternative arrangements for the accommodation, care and secure environment required by the resident, and (c) keep the resident and the resident's substitute decision-maker, informed and give the resident and the resident's SDM an opportunity to participate in the discharge planning and take their wishes into consideration.

A complaint was submitted to the Ministry of Health and Long-term Care indicating that resident #001 was discharged from the home and that this discharge was not in compliance with the Long-Term Care Homes Act and Regulations.

Inspector #542 reviewed resident #001's archived health care record. The progress

notes indicated that on a specific day, resident #001 was found with a co-resident in their room. Resident #001 was witnessed to be very angry and aggressive towards staff and their co-resident.

On another day, resident #001 was found to be pushing another resident in , very quickly with an angry expression on their face. Resident was difficult to distract. Resident then started being aggressive towards other residents and staff. At one time resident #001 attempted to strike out at a staff member. Resident #001 was transferred to the hospital this day due to their responsive behaviours. Resident #001 was admitted to the hospital.

An interview with the Medical Director, the Acting Administrator, the Director of Nursing (DON) and the resident's SDM confirmed that the resident was discharged from the home 6 days after being transferred to the hospital.

Inspector #542 spoke with resident #001's SDM. They indicated that they were contacted by the home's DON on the day that resident #001 was discharged at approximately 1100 hours. They were told by the DON that resident #001 would be discharged from the home on that day. The SDM received a letter dated the day of the discharge from the home's Administrator 7 days after being discharged, which stated that resident #001 was discharged from Golden Manor. The SDM stated that no one from the home had previously discussed with them or the resident the discharge of resident #001 from the home, prior to discharge.

Inspector #542 reviewed the letter dated the day of the discharge that the SDM received from the home 7 days later. The letter was signed by the Administrator at the time of the discharge. It stated that the Administrator felt that the home does not have sufficiently trained staff to meet resident #001's behaviour needs. It also stated that the home had "collaborated as a team to explore alternatives to discharge" and "has consulted other resources". The letter further stated that none of these resources were able to provide the home "with supports/interventions" to ensure both [resident' #001's] safety and the safety of other residents and staff."

The content of this letter was contradicted by the Director of Nursing (DON) and the Acting Administrator. Inspector #542 interviewed the DON and the Acting Administrator who confirmed that resident #001 was discharged from the home, by the home's previous Administrator. The DON told the inspector that the previous Administrator did not consult with anyone, including the appropriate placement coordinator or the resident or the resident's SDM, regarding the discharge of the resident. Both the DON and the

Acting Administrator told the inspector that the home had not considered or tried any alternatives prior to discharging the resident from the home.

The DON told the inspector that the hospital scheduled a meeting with staff from the home on the day that resident #001 was discharge, at 1330 hours to discuss future discharge plans for resident #001, from the hospital back to the home. The DON stated that the home's Administrator, returned to work on that same day, after their vacation and was made aware of the incident that occurred involving resident #001. They were also informed by the DON that the hospital had scheduled a meeting to discuss the future discharge plans for resident #001 to return to the home. The DON told the inspector that they were told by the Administrator that they would not be accepting the resident back to the home and that they would be discharging the resident. The DON was instructed by the Administrator to contact the resident's Substitute Decision-Maker (SDM) to inform them that they were discharging resident #001 from the home. The DON was also instructed by the Administrator to call the home's Medical Director and the resident's primary care physician attending to the resident at the hospital to inform them of the discharge. The DON told the Inspector that the Administrator did not consult with anyone regarding the discharge of the resident. No staff from the home attended the meeting scheduled at the hospital to discuss the future discharge of resident #001 back to the home.

Inspector #542 interviewed resident #001's primary care physician. The physician, who was attending the resident while they were in the hospital indicated that the home's Administrator did not consult or collaborate with them prior to or regarding the discharge of the resident. The physician stated that they were only informed by the home's Administrator that they would be discharging resident #001.

Therefore the home failed to (a) consider alternatives to discharge and, where appropriate, try alternatives, (b) collaborate with the appropriate placement co-ordinator and other health service organizations and make alternative arrangements for the accommodation, care and secure environment required by the resident, and (c) keep the resident and the resident's SDM an opportunity to participate in the discharge planning and take their wishes into consideration. [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 O.Reg 79/10, s. 145. When licensee may discharge

Specifically failed to comply with the following:

s. 145. (1) A licensee of a long-term care home may discharge a resident if the licensee is informed by someone permitted to do so under subsection (2) that the resident's requirements for care have changed and that, as a result, the home cannot provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come into contact with the resident. O. Reg. 79/10, s. 145 (1).

Findings/Faits saillants :

1. Resident #001 was discharged from the home. At this time, resident #001 was in hospital.

The licensee failed to ensure that when resident #001 was discharged from the home for safety reasons, that the resident's physician or a registered nurse in the extended class attending the resident at the hospital, informed the licensee that the resident's requirements for care had changed and that, as a result, the home could not provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who came into contact with the resident.

A complaint was submitted to the Ministry of Health and Long-term Care indicating that resident #001 was discharged from the home and that this discharge was not in compliance with the Long-Term Care Homes Act and Regulations. A letter was also received by the Advocacy Centre for the Elderly outlining the complainant's concerns regarding the discharge of resident #001 from the home.

Inspector #542 reviewed resident #001's archived health care record. The progress notes indicated that on a specific day, resident #001 was found with a co-resident in their room. Resident #001 was witnessed to be very angry and aggressive towards staff and their co-resident.

On another day, resident #001 was found to be pushing another resident in , very quickly with an angry expression on their face. Resident was difficult to distract. Resident then started being aggressive towards other residents and staff. At one time resident #001 attempted to strike out at a staff member. Resident #001 was transferred to the hospital this day due to their responsive behaviours. Resident #001 was admitted to the hospital.

An interview with the Medical Director, the Acting Administrator, the Director of Nursing (DON) and the resident's SDM confirmed that the resident was discharged from the home 6 days after being transferred to the hospital.

Inspector #542 spoke with resident #001's SDM. They indicated that they were contacted by the home's DON on the day that resident #001 was discharged at approximately 1100 hours. They were told by the DON that resident #001 would be discharged from the home on that day. The SDM received a letter dated the day of the discharge from the home's Administrator 7 days after being discharged, which stated that resident #001 was discharged from Golden Manor.

Inspector #542 reviewed the letter dated the day of the discharge that the SDM received from the home 7 days later. The letter was signed by the Administrator at the time of the discharge. It stated that the licensee can discharge a resident if the home cannot provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come in contact with the resident. The letter also stated that "in consultation with the health care team", the Administrator felt that the home does not have sufficiently trained staff to meet resident #001's behaviour needs as the resident's "behaviour poses a significant threat to the safety of other resident's and employees at Golden Manor."

Inspector #542 interviewed the home's Director of Nursing (DON). They told the inspector that the hospital scheduled a meeting with the staff from the home to discuss future discharge plans from the hospital back to the home. The DON stated that the home's Administrator, returned to work on that day after their vacation and was made aware of the incidents involving resident #001. They were also informed by the DON that the hospital had scheduled a meeting to discuss the future discharge plans for resident #001 to return to the home. The DON told the inspector that they were told by the Administrator that they would not be accepting the resident back to the home and that they would be discharging the resident. The DON was instructed by the Administrator to

contact the resident's Substitute Decision-Maker (SDM) to inform them that they were discharging resident #001 from the home. The DON was also instructed by the Administrator to call the home's Medical Director and the resident's primary care physician attending to the resident at the hospital to inform them of the discharge. The DON told the Inspector that the Administrator did not consult with anyone regarding the discharge of the resident. No staff from the home attended the meeting scheduled at the hospital to discuss the future discharge of resident #001 back to the home.

Inspector #542 interviewed the home's Medical Director who confirmed that they were not consulted by anyone from the home and did not have any discussions with anyone from the home regarding the discharge of resident #001.

Inspector #542 interviewed resident #001's primary care physician. The physician, who was attending the resident while they were in the hospital told the inspector that the home's Administrator did not consult with them regarding the discharge of the resident. Because the physician was not consulted about the resident's discharge from the home, the physician did not provide any information to anyone from the home about any change in the resident's requirements for care or whether any change in the care requirements meant that the home could not provide a sufficiently secure environment to ensure the safety of the resident or persons who come in contact with the resident. The physician told the inspector that they were only informed by the home's Administrator that the home was discharging resident #001. [s. 145. (1)]

Additional Required Actions:

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

Issued on this 29th day of March, 2016

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 sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JENNIFER LAURICELLA (542)
Inspection No. / No de l'inspection :	2016_281542_0008
Log No. / Registre no:	003284-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 24, 2016
Licensee / Titulaire de permis :	The Corporation of the City of Timmins 481 Melrose Blvd., TIMMINS, ON, P4N-5H3
LTC Home / Foyer de SLD :	GOLDEN MANOR 481 MELROSE BOULEVARD, TIMMINS, ON, P4N-5H3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Carol Halt

To The Corporation of the City of Timmins, 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

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

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 shall ensure that in the case of resident #001, if the resident is to be discharged in the future, that the following are met prior to discharge:

1) That alternatives to discharge have been considered and, where appropriate, tried.

2) That there is collaboration with the appropriate placement co-ordinator and other health service organizations, and that alternative arrangements for the accommodation, care and secure environment required by the resident are made.

3) That resident #001 and their Substitute Decision-Maker (SDM) are kept informed and given an opportunity to participate in the discharge planning.

4) That a written notice is provided to the resident, resident's SDM, setting out a detailed explanation of the supporting facts, as they related both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

Grounds / Motifs :

1. Before the licensee purported to discharge resident #001 under subsection 145 (1), the licensee failed to (a) consider alternatives to discharge and where appropriate, try alternatives, (b) collaborate with the appropriate placement co-ordinator and other health service organizations and make alternative arrangements for the accommodation, care and secure environment required by the resident, and (c) keep the resident and the resident's substitute decision-maker, informed and give the resident and the resident's SDM an opportunity to participate in the discharge planning and take their wishes into consideration.

A complaint was submitted to the Ministry of Health and Long-term Care indicating that resident #001 was discharged from the home and that this discharge was not in compliance with the Long-Term Care Homes Act and Regulations.

Inspector #542 reviewed resident #001's archived health care record. The progress notes indicated that on a specific day, resident #001 was found with a co-resident in their room. Resident #001 was witnessed to be very angry and aggressive towards staff and their co-resident.

On another day, resident #001 was found to be pushing another resident in , very quickly with an angry expression on their face. Resident was difficult to distract. Resident then started being aggressive towards other residents and staff. At one time resident #001 attempted to strike out at a staff member. Resident #001 was transferred to the hospital this day due to their responsive behaviours. Resident #001 was admitted to the hospital.

An interview with the Medical Director, the Acting Administrator, the Director of Nursing (DON) and the resident's SDM confirmed that the resident was discharged from the home 6 days after being transferred to the hospital.

Inspector #542 spoke with resident #001's SDM. They indicated that they were contacted by the home's DON on the day that resident #001 was discharged at approximately 1100 hours. They were told by the DON that resident #001 would be discharged from the home on that day. The SDM received a letter dated the day of the discharge from the home's Administrator 7 days after being discharged, which stated that resident #001 was discharged from Golden Manor. The SDM stated that no one from the home had previously discussed with them or the resident the discharge of resident #001 from the home, prior to discharge.

Inspector #542 reviewed the letter dated the day of the discharge that the SDM received from the home 7 days later. The letter was signed by the Administrator at the time of the discharge. It stated that the Administrator felt that the home does not have sufficiently trained staff to meet resident #001's behaviour needs. It also stated that the home had "collaborated as a team to explore alternatives to discharge" and "has consulted other resources". The letter further stated that none of these resources were able to provide the home "with supports/interventions" to ensure both [resident' #001's] safety and the safety of other residents and staff."

The content of this letter was contradicted by the Director of Nursing (DON) and the Acting Administrator. Inspector #542 interviewed the DON and the Acting Administrator who confirmed that resident #001 was discharged from the home, by the home's previous Administrator. The DON told the inspector that the previous Administrator did not consult with anyone, including the appropriate placement coordinator or the resident or the resident's SDM, regarding the discharge of the resident. Both the DON and the Acting Administrator told the inspector that the home had not considered or tried any alternatives prior to

discharging the resident from the home.

The DON told the inspector that the hospital scheduled a meeting with staff from the home on the day that resident #001 was discharge, at 1330 hours to discuss future discharge plans for resident #001, from the hospital back to the home. The DON stated that the home's Administrator, returned to work on that same day, after their vacation and was made aware of the incident that occurred involving resident #001. They were also informed by the DON that the hospital had scheduled a meeting to discuss the future discharge plans for resident #001 to return to the home. The DON told the inspector that they were told by the Administrator that they would not be accepting the resident back to the home and that they would be discharging the resident. The DON was instructed by the Administrator to contact the resident's Substitute Decision-Maker (SDM) to inform them that they were discharging resident #001 from the home. The DON was also instructed by the Administrator to call the home's Medical Director and the resident's primary care physician attending to the resident at the hospital to inform them of the discharge. The DON told the Inspector that the Administrator did not consult with anyone regarding the discharge of the resident. No staff from the home attended the meeting scheduled at the hospital to discuss the future discharge of resident #001 back to the home.

Inspector #542 interviewed resident #001's primary care physician. The physician, who was attending the resident while they were in the hospital indicated that the home's Administrator did not consult or collaborate with them prior to or regarding the discharge of the resident. The physician stated that they were only informed by the home's Administrator that they would be discharging resident #001.

Therefore the home failed to (a) consider alternatives to discharge and, where appropriate, try alternatives, (b) collaborate with the appropriate placement co-ordinator and other health service organizations and make alternative arrangements for the accommodation, care and secure environment required by the resident, and (c) keep the resident and the resident's SDM an opportunity to participate in the discharge planning and take their wishes into consideration.

Despite the home not having any previous non compliances under O. Reg. 79/10, s. 148 (2), the decision to issue the compliance order was based on the severity of, the risk or potential for actual harm to resident #001. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 30, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 145. (1) A licensee of a long-term care home may discharge a resident if the licensee is informed by someone permitted to do so under subsection (2) that the resident's requirements for care have changed and that, as a result, the home cannot provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come into contact with the resident. O. Reg. 79/10, s. 145 (1).

Order / Ordre :

The discharge of resident #001 on January 15, 2016 was not valid because it violated O. Reg. 79/10, s. 145 (1) and (2).

The licensee shall ensure that if resident #001 is discharged from Golden Manor pursuant to section 145(1), that the resident is discharged in accordance with the requirements for being informed by the appropriate person permitted to do so as described in O. Reg. 79/10, s. 145 (2).

In the event that resident #001 is transferred from the hospital back to Golden Manor, the licensee shall put in place measures to ensure that resident #001 and all residents and staff are kept safe.

Grounds / Motifs :

1. Resident #001 was discharged from the home. At this time, resident #001 was in hospital.

The licensee failed to ensure that when resident #001 was discharged from the home for safety reasons, that the resident's physician or a registered nurse in the extended class attending the resident at the hospital, informed the licensee that the resident's requirements for care had changed and that, as a result, the home could not provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who came into contact with the resident.

A complaint was submitted to the Ministry of Health and Long-term Care

indicating that resident #001 was discharged from the home and that this discharge was not in compliance with the Long-Term Care Homes Act and Regulations. A letter was also received by the Advocacy Centre for the Elderly outlining the complainant's concerns regarding the discharge of resident #001 from the home.

Inspector #542 reviewed resident #001's archived health care record. The progress notes indicated that on a specific day, resident #001 was found with a co-resident in their room. Resident #001 was witnessed to be very angry and aggressive towards staff and their co-resident.

On another day, resident #001 was found to be pushing another resident in , very quickly with an angry expression on their face. Resident was difficult to distract. Resident then started being aggressive towards other residents and staff. At one time resident #001 attempted to strike out at a staff member. Resident #001 was transferred to the hospital this day due to their responsive behaviours. Resident #001 was admitted to the hospital.

An interview with the Medical Director, the Acting Administrator, the Director of Nursing (DON) and the resident's SDM confirmed that the resident was discharged from the home 6 days after being transferred to the hospital.

Inspector #542 spoke with resident #001's SDM. They indicated that they were contacted by the home's DON on the day that resident #001 was discharged at approximately 1100 hours. They were told by the DON that resident #001 would be discharged from the home on that day. The SDM received a letter dated the day of the discharge from the home's Administrator 7 days after being discharged, which stated that resident #001 was discharged from Golden Manor.

Inspector #542 reviewed the letter dated the day of the discharge that the SDM received from the home 7 days later. The letter was signed by the Administrator at the time of the discharge. It stated that the licensee can discharge a resident if the home cannot provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come in contact with the resident. The letter also stated that "in consultation with the health care team", the Administrator felt that the home does not have sufficiently trained staff to meet resident #001's behaviour needs as the resident's "behaviour poses a significant threat to the safety of other resident's and employees at Golden Manor."

Inspector #542 interviewed the home's Director of Nursing (DON). They told the inspector that the hospital scheduled a meeting with the staff from the home to discuss future discharge plans from the hospital back to the home. The DON stated that the home's Administrator, returned to work on that day after their vacation and was made aware of the incidents involving resident #001. They were also informed by the DON that the hospital had scheduled a meeting to discuss the future discharge plans for resident #001 to return to the home. The DON told the inspector that they were told by the Administrator that they would not be accepting the resident back to the home and that they would be discharging the resident. The DON was instructed by the Administrator to contact the resident's Substitute Decision-Maker (SDM) to inform them that they were discharging resident #001 from the home. The DON was also instructed by the Administrator to call the home's Medical Director and the resident's primary care physician attending to the resident at the hospital to inform them of the discharge. The DON told the Inspector that the Administrator did not consult with anyone regarding the discharge of the resident. No staff from the home attended the meeting scheduled at the hospital to discuss the future discharge of resident #001 back to the home.

Inspector #542 interviewed the home's Medical Director who confirmed that they were not consulted by anyone from the home and did not have any discussions with anyone from the home regarding the discharge of resident #001.

Inspector #542 interviewed resident #001's primary care physician. The physician, who was attending the resident while they were in the hospital told the inspector that the home's Administrator did not consult with them regarding the discharge of the resident. Because the physician was not consulted about the resident's discharge from the home, the physician did not provide any information to anyone from the home about any change in the resident's requirements for care or whether any change in the care requirements meant that the home could not provide a sufficiently secure environment to ensure the safety of the resident or persons who come in contact with the resident. The physician told the inspector that they were only informed by the home's Administrator that the home was discharging resident #001.

Despite the home not having any previous non compliances under O. Reg 79/10, s. 145 (1), and the scope being isolated, the decision to issue a compliance order was based on the severity, the risk or potential for actual harm

to resident #001 and other residents. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 30, 2016

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 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 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
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La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 24th day of March, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Lauricella

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