Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 6, 2021	2020_669642_0021	021198-20, 022250-20, 022854-20	Complaint

Licensee/Titulaire de permis

Wikwemikong Nursing Home Limited
2281 Wikwemikong Way P.O. Box 114 Wikwemikong ON P0P 2J0

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

Wikwemikong Nursing Home
2281 Wikwemikong Way P.O. Box 114 Wikwemikong ON P0P 2J0

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

AMY GEAUVREAU (642), LOVIRIZA CALUZA (687)

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 16-20, 23-27, 2020.

The following intakes were completed during this Complaint (CO) Inspection:

-One complaint to the Director, related to allegations that a resident was not properly discharged from the home;

-One complaint to the Director, related to family care concerns of a resident; and

-One complaint to the Director, related to allegations that the home had potential unsafe areas and falls prevention and management concerns.

A Critical Incident System Inspection #2020_669642_0022, was conducted concurrently with this Complaint Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Cares (DOCs), Physician, Registered Dietitian (RD), Behavioural Support Ontario (BSO) Clinical Lead, Activity Manager, Maintenance Supervisor, Dietary Manager, Maintenance staff, Finance Officer, Physiotherapist, Physiotherapist Assistant, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeepers, family members, and residents.

The Inspectors also conducted a tour of the resident care areas, reviewed relevant resident records and policies, and observed resident rooms, resident common areas, and the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Dining Observation
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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

- **3 WN(s)**
- **0 VPC(s)**
- **4 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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the door in one of the home areas (or zones) was kept closed and locked.

A complaint had been submitted to the Director that identified a resident was able to enter a non-resident area. A review of the progress notes for this resident identified a Housekeeper had unlocked and left a door to a non-resident area open.

An interview with the Housekeeper identified they had propped the door open. The housekeeper stated that door should not have been left open and unlocked.

An interview with the Administrator, stated the doors in that specific zone, should always be locked and closed.

Resources: Resident's progress notes; fall, and skin and wound assessments; Interview with the complainant; Interview with Housekeeper, and the Administrator. [s. 9. (1)]

2. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and were kept locked when they were not being supervised by staff.

A complaint had been submitted that identified a resident had entered a non-resident area that should have been locked.

A review of the resident’s progress notes, identified the resident had accessed a specific room, equipped with a lock that was considered a non-residential area.

The current DOC, stated they were the staff member who assessed this resident, and had identified that the resident was not supposed to be in that area. The Administrator stated that specific room was required to be locked when not being supervised by staff.

Resources: Complaint report; Interview with the complainant; resident’s progress notes; Interviews with the current DOC, and Administrator. [s. 9. (1) 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. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (6) The licensee shall ensure that the emergency plans for the home are evaluated and updated at least annually, including the updating of all emergency contact information. O. Reg. 79/10, s. 230 (6).

s. 230. (7) The licensee shall,
(a) test the emergency plans related to the loss of essential services, fires, situations involving a missing resident, medical emergencies and violent outbursts on an annual basis, including the arrangements with the community agencies, partner facilities and resources that will be involved in responding to an emergency; O. Reg. 79/10, s. 230 (7).
(b) test all other emergency plans at least once every three years, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency; O. Reg. 79/10, s. 230 (7).
(c) conduct a planned evacuation at least once every three years; and O. Reg. 79/10, s. 230 (7).
(d) keep a written record of the testing of the emergency plans and planned evacuation and of the changes made to improve the plans. O. Reg. 79/10, s. 230 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Fire Emergency Plan for the home was evaluated and updated at least annually.

An interview with the current DOC, and Administrator identified the last time the emergency Plan for the Fire Safety Plan, was evaluated was 2018, they stated that it had not been completed annually in 2019, or 2020.

Sources: Complaint report, Interview with the complainant; Interviews with the Administrator and the current DOC. [s. 230. (6)]

2. The licensee has failed to ensure that the emergency plan for fires were tested on an annual basis, and that the home had a written record of the testing of the emergency fire

plan, and the changes made to improve the plan.

Specifically, staff did not comply with the licensee's policy regarding, "Fire Safety Plan," which identified the home was required to do monthly fire drills; and to keep the sign in sheet showing attendance at the drills; all records of the fire drill attendance would be maintained in the home for a period of two years; and any changes made to improve the plan.

Interviews completed with different staff in the home identified that there had been no monthly fire drills completed, and it was unclear when the last fire drill had been completed.

During an interview with the current DOC, they identified the last record they had of a fire alarm drill with a full evacuation of the home was from 2019. This was the only document they could find of any previous fire drill.

A review of the home's Fire Safety Plan with the Administrator, who stated that there should have been monthly fire drills completed and documentation of staff signatures should have been maintained in the home for two years and that the Maintenance Supervisor was required to keep these records.

An interview with the current Maintenance Supervisor, indicated they had not completed any monthly fire drills, and could not find any records of staff signatures of any previous fire drills or any documents related to the Fire Safety Plan from the previous Supervisor.

Sources: Licensee's policy regarding the, Fire Safety Plan, last revised December, 2018; Interviews with Administrator, current DOC, current Maintenance Supervisor, and other staff. [s. 230. (7)]

Additional Required Actions:

CO # - 002, 003 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. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that before discharging a resident under section, 145 (1), the licensee shall, in collaboration with the appropriate placement coordinator and other health services organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident.

A complaint was submitted to the Director, which outlined concerns from the Local Health Integration Network (LHIN) that the home had discharged a resident, without attempts to facilitate the resident's return to the home.

The Inspector reviewed the home's Transfer/Discharge Record report which indicated that the resident was transferred to a Health Centre, and was then discharged from the home the next day.

A review of the home's policy titled, "Discharge Planning", indicated that, "In collaboration with the resident and/or the Substitute Decision Maker, the staff would endeavor to identify appropriate placement options if this would be the wish of the resident. Facility staff would liaise with the Community Care Access Centre (CCAC) to assist the resident

in coordinating community-based services if discharge was planned."

During an interview with the resident's Physician, they stated that they did not discharge this resident from the home and that they were not part of the discharge planning process for the resident.

In an interview with the current DOC, they stated that the previous DOC had discharged this resident and there was no discharge planning that occurred prior to the resident's discharge. The current DOC further stated that the previous DOC, did not follow the Discharge Policy regarding this resident.

During an interview with the Administrator, they acknowledged that they had received an electronic copy of this resident's discharge letter, from the previous DOC to the LHIN, the Community Navigator and to the Health Center staff members. The Administrator further acknowledged that they were not made aware of any discharge planning for this resident prior to the resident's discharge, and that their Discharge Policy was not followed.

Sources: Complaint log; review of the resident's electronic progress notes and care plan documentation; review of the home's policy titled, Discharge Planning; Interview with the complainant, the Physician, a PSW, Finance Officer, the current DOC, and the Administrator. [s. 148. (2)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 18th day of January, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMY GEAUVREAU (642), LOVIRIZA CALUZA (687)
Inspection No. / No de l'inspection :	2020_669642_0021
Log No. / No de registre :	021198-20, 022250-20, 022854-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 6, 2021
Licensee / Titulaire de permis :	Wikwemikong Nursing Home Limited 2281 Wikwemikong Way, P.O. Box 114, Wikwemikong, ON, P0P-2J0
LTC Home / Foyer de SLD :	Wikwemikong Nursing Home 2281 Wikwemikong Way, P.O. Box 114, Wikwemikong, ON, P0P-2J0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cheryl Osawabine-Peltier

Ontario

Ministry of Long-Term Care

Ministère 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 Wikwemikong Nursing Home Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère 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 # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii.equipped with a door access control system that is kept on at all times, and
   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee must be compliant with s. 9 (1) of O. Reg. 79/10.

Specifically, the licensee must:

1) Ensure the doors leading to outside unsecured areas of the home are closed and locked at all times;

2) Ensure that a new process is in place, so the doors are not left unlocked; and,

3) Ensure that areas that are to be locked and inaccessible to residents have a secure lock.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the door in one of the home areas (or zones) was kept closed and locked.

A complaint had been submitted to the Director that identified a resident was able to enter a non-resident area. A review of the progress notes for this resident identified a Housekeeper had unlocked and left a door to a non-resident area open.

An interview with the Housekeeper identified they had propped the door open. The housekeeper stated that door should not have been left open and unlocked.

An interview with the Administrator, stated the doors in that specific zone, should always be locked and closed.

Resources: Resident's progress notes; fall, and skin and wound assessments; Interview with the complainant; Interview with Housekeeper, and the Administrator.
(642)

2. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and were kept locked when they were not being supervised by staff.

A complaint had been submitted that identified a resident had entered a non-resident area that should have been locked.

A review of the resident's progress notes, identified the resident had accessed a specific room, equipped with a lock that was considered a non-residential area.

The current DOC, stated they were the staff member who assessed this resident, and had identified that the resident was not supposed to be in that area. The Administrator stated that specific room was required to be locked when not being supervised by staff.

Resources: Complaint report; Interview with the complainant; resident's progress notes; Interviews with the current DOC, and Administrator.

An Order was made by taking the following factors into account:

Severity: The door in a specific zone had been unlocked and propped open, by a staff member, there was actual risk of harm to a resident.

Scope: The scope of this non-compliance was identified as a pattern, after review of residents' for a safe and secure home.

Compliance History: One voluntary plan of action (VPC) had been issued to the home in 2020 which was related to the same sub-section of the legislation in the past 36 months.
(642)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 05, 2021

Ontario

Ministry of Long-Term Care

Ministère 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 # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 230. (7) The licensee shall,
(a) test the emergency plans related to the loss of essential services, fires, situations involving a missing resident, medical emergencies and violent outbursts on an annual basis, including the arrangements with the community agencies, partner facilities and resources that will be involved in responding to an emergency;
(b) test all other emergency plans at least once every three years, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency;
(c) conduct a planned evacuation at least once every three years; and
(d) keep a written record of the testing of the emergency plans and planned evacuation and of the changes made to improve the plans. O. Reg. 79/10, s. 230 (7).

Order / Ordre :

The licensee must comply with O. Reg. 79/10, s 230 (7).

Specifically, the licensee must:

1) Follow their Fire Safety Plan;

2) The licensee must keep documentation of all the staff members who attend the fire drills; per the Fire Safety Plan for up to two years;

3) The documents for the Fire Safety Plan attendance; and any changes made to improve the plans, will be provided to an Inspector when requested.

Grounds / Motifs :

1. The licensee has failed to ensure that the emergency plan for fires were tested on an annual basis, and that the home had a written record of the testing of the emergency fire plan, and the changes made to improve the plan.

Specifically, staff did not comply with the licensee's policy regarding, "Fire Safety Plan," which identified the home was required to do monthly fire drills; and to keep the sign in sheet showing attendance at the drills; all records of the fire drill attendance would be maintained in the home for a period of two years; and any changes made to improve the plan.

Interviews completed with different staff in the home identified that there had been no monthly fire drills completed, and it was unclear when the last fire drill had been completed.

During an interview with the current DOC, they identified the last record they had of a fire alarm drill with a full evacuation of the home was from 2019. This was the only document they could find of any previous fire drill.

A review of the home's Fire Safety Plan with the Administrator, who stated that there should have been monthly fire drills completed and documentation of staff signatures should have been maintained in the home for two years and that the Maintenance Supervisor was required to keep these records.

An interview with the current Maintenance Supervisor, indicated they had not completed any monthly fire drills, and could not find any records of staff signatures of any previous fire drills or any documents related to the Fire Safety Plan from the previous Supervisor.

An Order was made by taking the following factors into account:

Severity: The home had not followed their Fire Safety Plan, which required monthly fire drills to be completed. There was minimal risk of harm to the residents.

Scope: This non-compliance was widespread as all staff interviewed could not identify a specific month that a fire drill had last been completed and no documentation of staff attendance was provided for any previous fire drills.

Compliance History: There was previous non-compliance to a different subsection in the last 36 months.
(642)

Ontario

Ministry of Long-Term Care

Ministère 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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Mar 05, 2021

Ontario

Ministry of Long-Term Care

Ministère 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 # / No d'ordre : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 230. (6) The licensee shall ensure that the emergency plans for the home are evaluated and updated at least annually, including the updating of all emergency contact information. O. Reg. 79/10, s. 230 (6).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 230 (6).

Specifically, the licensee must:

1) Ensure the emergency Fire plans for the home are evaluated and updated at least annually.

2) Ensure the documentation is kept in the home, and will be provided to the Inspector when requested.

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. The licensee has failed to ensure that the Fire Emergency Plan for the home was evaluated and updated at least annually.

An interview with the current DOC, and Administrator identified the last time the emergency Plan for the Fire Safety Plan, was evaluated was 2018, they stated that it had not been completed annually in 2019, or 2020.

Sources: Complaint report, Interview with the complainant; Interviews with the Administrator and the current DOC.

An Order was made by taking the following factors into account:

Severity: The home had not evaluated and updated the Fire Emergency Plan annually. There was minimal risk of harm to the residents.

Scope: This was identified as widespread since the home could not provide any documentation for any previous Fire plans being reviewed yearly.

Compliance History: There was previous non-compliance to a different subsection in the last 36 months.
(642)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Mar 05, 2021

Ontario

Ministry of Long-Term Care

Ministère 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 # / No d'ordre : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,

(a) ensure that alternatives to discharge have been considered and, where appropriate, tried;

(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident;

(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and

(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Order / Ordre :

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

Specifically, the licensee must:

1) Ensure that alternatives to discharge have been considered and where appropriate, tried, for all residents who may be discharged, the licensee will collaborate with the resident and/or the enacted Substitute Decision Maker (SDM), to identify appropriate placement options if discharge was planned.

2) Ensure that all residents who may be discharged, ensure the licensee will liaise with the Local Health Integration Network (LHIN), to assist the resident in coordinating community-based services prior to a planned discharge.

3) Ensure that registered staff members including the Administrator and the Director of Care review the home's policy titled, Discharge Planning, specifically but not limited to the area of discharge procedure. This process should be documented to include; the dates of the review, the names and classifications of the staff who completed the review, the content of the review, and any other pertinent documents.

Grounds / Motifs :

1. The licensee has failed to ensure that before discharging a resident under section, 145 (1), the licensee shall, in collaboration with the appropriate placement coordinator and other health services organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident.

A complaint was submitted to the Director, which outlined concerns from the Local Health Integration Network (LHIN) that the home had discharged a resident, without attempts to facilitate the resident's return to the home.

The Inspector reviewed the home's Transfer/Discharge Record report which indicated that the resident was transferred to a Health Centre, and was then discharged from the home the next day.

A review of the home's policy titled, "Discharge Planning", indicated that, "In collaboration with the resident and/or the Substitute Decision Maker, the staff

would endeavor to identify appropriate placement options if this would be the wish of the resident. Facility staff would liaise with the Community Care Access Centre (CCAC) to assist the resident in coordinating community-based services if discharge was planned."

During an interview with the resident's Physician, they stated that they did not discharge this resident from the home and that they were not part of the discharge planning process for the resident.

In an interview with the current DOC, they stated that the previous DOC had discharged this resident and there was no discharge planning that occurred prior to the resident's discharge. The current DOC further stated that the previous DOC, did not follow the Discharge Policy regarding this resident.

During an interview with the Administrator, they acknowledged that they had received an electronic copy of this resident's discharge letter, from the previous DOC to the LHIN, the Community Navigator and to the Health Center staff members. The Administrator further acknowledged that they were not made aware of any discharge planning for this resident prior to the resident's discharge, and that their Discharge Policy was not followed.

Sources: Complaint log; review of the resident's electronic progress notes and care plan documentation; review of the home's policy titled, Discharge Planning; Interview with the complainant, the Physician, a PSW, Finance Officer, the current DOC, and the Administrator.

The Compliance Order was made by taking the following factors into account:

Severity: There was no actual harm to the resident, the home had not followed their policy in relation to properly discharging a resident, they had not reached out to appropriate placement coordinator, and other health service organizations, to make alternative arrangements for their accommodations.

Scope: The scope of the non-compliance was isolated.

Compliance History: There was previous non-compliance to a different subsection in the past 36 months.

Ontario

Ministry of Long-Term Care

Ministère 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

(687)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Mar 05, 2021

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 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 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 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 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 6th day of January, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amy Geauvreau

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