Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 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 #/ Registre no	Type of Inspection / Genre d'inspection
Jul 19, 2017;	2017_639607_0012 (A1)	004316-17, 004335-17	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

WINBOURNE PARK
1020 Westney Road North AJAX ON L1T 4K6

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

JULIET MANDERSON-GRAY (607) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The Licensee requested a review of the report, changes were required to wording in findings.

Ontario

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

Ministère de la Santé et des Soins de longue durée

Rapport d’inspection prévue le Loi de 2007 les foyers de soins de longue durée

Issued on this 19 day of July 2017 (A1)

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

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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1020 Westney Road North AJAX ON L1T 4K6

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

JULIET MANDERSON-GRAY (607) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): May 29, 30, 31, June 1, and 2, 2017.

During this Complaint Inspection the following intakes were inspected: Logs # 004335-17 and #004316-17.

Summary of Intakes:

1) 004335-17: A complaint related to an alleged staff to resident physical abuse.

2) 004316-17: A Critical Incident Report (CIR), regarding a fall that resulted in injury for which a resident was taken to hospital.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Physiotherapist (PT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and a Family Member.

During the course of the inspection, the Inspector reviewed Clinical Health Records, observed staff to resident interactions, reviewed Training Records, Evaluation of Abuse and Falls Programs, home specific policies related to Resident Non-Abuse, Safe Resident Handling and Fall Prevention and Injury.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Hospitalization and Change in Condition

Prevention of Abuse, Neglect and Retaliation

Resident Charges

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

4 WN(s)
2 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 91. Resident charges

Specifically failed to comply with the following:

s. 91. (1) A licensee shall not charge a resident for anything, except in accordance with the following:
1. For basic accommodation, a resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).
2. For preferred accommodation, a resident shall not be charged more than can be charged for basic accommodation in accordance with paragraph 1 unless the preferred accommodation was provided under an agreement, in which case the resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).
3. For anything other than accommodation, a resident shall be charged only if it was provided under an agreement and shall not be charged more than the amount provided for in the regulations, or, if no amount is provided for, more than a reasonable amount. 2007, c. 8, s. 91 (1).
4. Despite paragraph 3, a resident shall not be charged for anything that the regulations provide is not to be charged for. 2007, c. 8, s. 91 (1).

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that a resident was not charged for anything except with in accordance with the following:
For anything other than accommodation, a resident shall be charged only if it was provided under an agreement and shall not be charged more than the amount provided for in the regulations, or, if no amount is provided for, more than a reasonable amount. 4. Despite paragraph 3, a resident shall not be charged for anything that the regulations provide is not to be charged for

Under 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:
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. Except in accordance 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.

Under Long Term Care-Service Accountability Agreement (L-SAA) Policy: LTCH Required Goods, Equipment, Supplies and Services, Date: 2010-07-01 indicated under section 2.1.12 Other Supplies and Equipment:
The licensee must provide the following goods, equipment, supplies and services to long-term care (LTC) home residents at no charge, other than the accommodation charge payable under the LongTerm Care Homes Act, 2007 (LTCHA), using the funding the licensee receives from the Local Health Integration Network under the Local Health System Integration Act, 2006 (LHSIA) or the Minister under the LTCHA or accommodation charges received under the LTCHA. The list of the goods, equipment, supplies and services the licensee must ensure is provided to residents, where not covered under another government program, is non-exhaustive and does not include a complete list of the goods, equipment, supplies and services the licensee must ensure is provided to residents to meet the requirements under O. Reg. 79/10. The classification of an expenditure into a particular funding envelope is determined in accordance with the Ministry's policy for classifying eligible expenditures and is not reflected in the order or organization of the following list:
2.1.12 Other Supplies and Equipment-Other supplies and equipment including but not limited to:
c. Equipment and supplies to ensure resident safety
d. Equipment and supplies to prevent resident falls

Review of the Progress Notes for resident #003, indicated that on an identified date in March 2017, a referral was sent to the Physiotherapist (PT) for a safety device for the resident. The PT contacted the resident's Family Member providing information to purchase the safety device. The PT documented that he/she emailed the Family Member of the resident, the product information cost. The Family Member agreed to the purchase of the safety device.

In a telephone interview with resident #003's Family Member, by Inspector #607 on two identified dates in June 2017, the Family Member indicated being sent an email by the PT, indicating resident #003 needed a safety device, due to ongoing falls. The Family Member further indicated being advised by the PT, that it was the family's responsibility to purchase the safety device. The Family Member indicated having purchased a total of two of the safety device for the resident.

In an interview with the PT, by Inspector #607, on an identified date in June 2017, indicated when a resident has fallen and requires a safety device, it is the family's responsibility to purchase the device for the resident. The PT indicated resident #003 required the device to minimize injury related to ongoing falls. Further interview with the PT on an identified date in June 2017, indicated that no other family members within the home have been asked to purchase any safety or fall prevention devices.

During an interview with the DOC, by Inspector #607 on an identified date in June 2017, The DOC indicated the device resident #003 uses, is a safety device that aids in the minimization of the resident injuries related to falls.

During an interview with the Administrator, by Inspector #607, on an identified date in June 2017, indicated the purchase of resident #003's safety device by a Family Member was an isolated incident. In addition, the Administrator indicated he/she had asked why was the Family Member paying for the device, and indicated by this time, the Family Member had already purchased and brought the device in, for resident #003. The Administrator indicated the home do not usually ask families to pay for any safety or fall prevention devices. [s. 91. (1) 3.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (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 resident #001 as specified in the plan related to falls risk.

This finding is being issued related to Log #009643-17, involving resident #001, related to Inspection #2017_639607_0011:

A Critical Incident Report (CIR), was submitted to the Director on an identified date and time in May 2017, for an incident related to an injury that occurred on an identified date and time in May 2017, involving resident #001. The CIR indicated, the resident had reported to a Personal Support Worker (PSW) that he/she had sustained an injury.

Resident #001 was observed during the inspection ambulating around an identified unit with no mobility aid.

A review of the Progress Notes for a three month period in 2017, indicated resident #001 had two incidents that resulted in injuries, for which the resident was taken to the hospital.

A review of resident #001's written plan of care currently in place related to falls, by Inspector #607, indicated resident #001 is at high risk for falls, and there were several interventions in place related to falls.

Interview with Personal Support Worker (PSW) #113, indicated to the Inspector,

that he/she provided care to resident #001 earlier during the shift and did not apply the resident's fall prevention devices, as he/she was unaware the resident required them.

Interview with Registered Practical Nurse #107, Inspector #607, on an identified date in May 2017, indicated that resident #001 does uses the fall prevention devices, and further indicated he/she did not observe the resident wearing them on that day.

Interview with the Director of Care (DOC), by Inspector #607, indicated it is the home's expectation of the PSWs, that if a resident has a fall prevention intervention in place, the PSWs are to check that it is applied and in place for functionability.

The licensee failed to ensure that the care set out in the plan of care provided to the resident #001, specifically related to not applying a fall prevention device, as specified in the plan of care. [s. 6.]

2. The licensee has failed to ensure that plan of care set out clear directions to staff and others who provide direct care to the resident #002.

Related to Log #004316-17 for resident #002:

A Complaint was submitted to the Ministry of Health and LongTerm Care (MOHLTC) on an identified date, indicating resident #002 sustained a fall involving a staff member, resulting in an injury. A Critical Incident Report (CIR), was also submitted to the Director on an identified date and time in February 2017, for the same incident. The CIR indicated that resident #002 sustained a fall during ambulation and indicated a Personal Support Worker (PSW) was present at the time of the incident.

A review of resident #002's written care plan in place at the time of the fall, and currently in place, indicated resident #002 has been assessed as being at Medium Risk for falls and had several fall prevention interventions in place.

A review of the Falls Risk Assessment Tool 2013 (FRAT) in the home's electronic record, completed on an identified date in March 2017, indicated the resident was at medium risk for falls. Further review of the Progress Notes, indicated resident #002 had three falls within the last six months: two with no injuries and one with injury.

A review of the Safe Ambulation Lift and Transfer 2016 (SALT) assessment tool in the home's electronic record, and observation of the resident's room, indicated there was a transfer symbol/logo in place that indicated resident #002's fall risk and further indicated that the resident is a two person transfer with the use of an identified transfer device. Further review of the written plan of care indicated the resident uses a transfer device that the resident was not currently assessed for.

Interview with PSW #112 and RN #101, by the Inspector, on an identified date in June 2017, both indicated that resident #002 was at high risk for falling and uses an identified transfer device for all transfers. In addition, RN #101 indicated resident #002 is now a two person transfer with the use of the an identified transfer device, and further indicated he/she completed the SALT assessment tool, and had forgotten to update the written care plan to include resident #002 transfer status.

Interview with the DOC, by Inspector #607, on an identified date in June 2017, indicated the expectation is that the written care plan should reflect the resident care needs related to assessments and transfers status.

The plan of care failed to provide clear direction to staff and others who provide direct care to resident #002, as the written plan of care identified the resident's falls risk as being medium, when the resident began having multiple falls. The plan of care did not indicate the resident uses an identified transfer device, when the resident's transfer status was changed. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident #002 as specified in the plan.

Related to Log #004316-17 for resident #002:

A review of resident #002's written care plan in place at the time of the fall, and currently in place, indicated resident #002 has been assessed as being at Medium Risk for falls as evidenced and had several identified interventions in place related to falls.

On an identified date in June, resident #002 was observed at five different time periods without fall interventions in place, as identified in the written plan of care.

Interview with Personal Support Worker (PSW) #112 and Registered Nurse (RN) #101, by Inspector #607, on an identified date in June 2017, both indicated resident #002's fall prevention devices were not applied according to the plan of care, and indicated the expectation is that the resident fall prevention interventions should be applied for the resident's safety.

Interview with the DOC, by Inspector #607, on an identified date in June 2017, indicated it is the home's expectation of the PSWs that if a resident has a fall prevention intervention in place, the PSWs are to check that it is applied and in place for functionability.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident #002 as specified in the plan, specifically related to fall prevention interventions not being applied, as specified in the written plan of care. [s. 6. (7)]

4. The licensee has failed to ensure that care set out in the plan of care was provided to the resident #003, as specified in the plan.

A review of resident #003's written plan of care currently in place related to falls, indicated the resident is at high risk for falls and had several fall prevention interventions in place.

A review of the Progress Notes for the months of December 2016 to May 2017, indicated the resident had several falls. In addition, the resident sustained several injuries in 2017 related to falls.

On an identified date in June 2017, resident #002 was observed without fall prevention interventions in place at three separate times, as specified in the written plan of care.

Interview with PSW #111 and RN #101, by Inspector #607, on an identified date in June 2017, indicated resident #003's fall prevention devices were not applied according to the plan of care, and indicated the expectation is the resident fall prevention interventions should be applied for the resident's safety.

Interview with the DOC by the Inspector, on an identified date in June 2017, indicated it is the home's expectation of the PSWs that if a resident has a fall prevention intervention in place, the PSWs are to check that it is applied and in

place for functionability.

The licensee failed to ensure that care set out in the plan of care was provided to the resident #003. [s. 6. (7)]

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 ensuring that the care set out in the plan of care was provided to the resident #002 as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied

with.

Under O. Reg. 79/10, s.48(1)1 every licensee of a LongTerm Care home shall ensure that the following interdisciplinary program is developed and implemented in the home: a falls prevention and management program to reduce the incidence of falls and risk of injury.

A review of the homes Fall Prevention and Injury Reduction policy # CARE5-010.02 directs:
-The nurse will complete a thorough head to toe assessment, including all limbs and joints before any transfers take place.

Interview with RPN #107 and the DOC, by Inspector #607, on an identified date in June 2017, both indicated after a resident fall, it is the home's expectation that a Head to Toe Assessment be completed and documented using the Head to Toe Assessment Tool in the home's electronic record system.

Further review of the clinical health records for resident #003, indicated the resident was at high risk for falls and had several falls. Of the falls the resident sustained, several Head to Toe assessments were not completed using the Head to Toe Assessment Tool in the home electronic record system. There were five incidents, where resident #003 sustained injuries related to falls, and a Head To Toe assessment was not completed.

The licensee failed to ensure that the Fall Prevention and Injury Reduction policy # CARE5-010.02 policy is complied with, specifically related to not ensuring head to toe assessment are completed and documented using the Head To Toe Assessment tool. [s. 8. (1) (a),s. 8. (1) (b)]

2. A review of the safe resident handling policy # CARE6-010.05 dated August 31, 2016 directs:
A Logo/ADL will reflect the use of a transfer.

Interview with PSW #111 and a review of the written plan of care, by Inspector #607, indicated resident #003 was at high risk for falls and requires a two person transfer by staff. The PSW further indicated a transfer sign/logo is usually located in the resident's room to indicate to staff a resident transfer status.

On an identified date and time in June 2017, an observation of resident #003's

room by Inspector #607, along with PSW #111 failed to locate a logo or transfer symbol, indicating resident #003's transfer status.

Interview with PSW #111 and RN #103, by Inspector #607, on an identified date in June 2017, both indicated a transfer logo should have been located in the resident's room.

Interview with DOC, by Inspector #607, on an identified date in June 2017, indicated that a transfer logo is usually located in a resident's rooms, and further indicated, it is the home's expectation that staff care for resident's, performing transfers, as indicated by the transfer logo located in residents' room. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the Fall Prevention and Injury Reduction policy # CARE5-010.02 was complied with, specifically related to resident #003, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #003 has fallen, the resident is assessed and, if required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A review of resident #003's written plan of care currently in place related to falls, indicated the resident is at high risk for falls and has several interventions in place related to falls.

Interview with RN #101, by Inspector #607, on an identified date in June 2017, indicated it is the home's expectation that post fall assessments are completed in the home's electronic records, for resident's sustaining falls, after every fall.

A review of the Post Fall Assessment record, indicated that there were several falls recorded for resident #003, where post fall assessments were not completed for three of the identified falls, on three identified dates; two in 2016 and one in 2017, using the home's Post Fall Assessment Tool.

Interview with the DOC, by Inspector #607 on an identified date in June 2017, indicated it is the home's expectation that Post fall assessments be completed for residents after every fall.

The licensee failed to ensure that when resident #002 has fallen, the resident was assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument, that is specifically designed for falls. [s. 49. (2)]

Issued on this 19 day of July 2017 (A1)

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
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Name of Inspector (ID #) / Nom de l'inspecteur (No) : JULIET MANDERSON-GRAY (607) - (A1)

Inspection No. / No de l'inspection : 2017_639607_0012 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 004316-17, 004335-17 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Jul 19, 2017;(A1)

Licensee / Titulaire de permis : REVERA LONG TERM CARE INC.
5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, 000-000

LTC Home / Foyer de SLD : WINBOURNE PARK
1020 Westney Road North, AJAX, ON, L1T-4K6

Name of Administrator / Nom de l'administratrice ou de l'administrateur : BEVERLEY RAYSIDE

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 REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 91. (1) A licensee shall not charge a resident for anything, except in accordance with the following:
1. For basic accommodation, a resident shall not be charged more than the amount provided for in the regulations for the accommodation provided.
2. For preferred accommodation, a resident shall not be charged more than can be charged for basic accommodation in accordance with paragraph 1 unless the preferred accommodation was provided under an agreement, in which case the resident shall not be charged more than the amount provided for in the regulations for the accommodation provided.
3. For anything other than accommodation, a resident shall be charged only if it was provided under an agreement and shall not be charged more than the amount provided for in the regulations, or, if no amount is provided for, more than a reasonable amount.
4. Despite paragraph 3, a resident shall not be charged for anything that the regulations provide is not to be charged for. 2007, c. 8, s. 91 (1).

Order / Ordre :

(A1)
The Licensee is hereby ordered to:

1) Immediately stop charging resident #003 or the resident' Substitute Decision Maker (SDM) for a safety device; and
2) Identify any resident who may have or have been charged for safety devices or any other fall protective equipment's and reimburse each resident or each resident's SDM, if any, for those charges.

Grounds / Motifs :

(A1)

1. The licensee has failed to ensure that for goods and services other than accommodation, residents are only charged if provided for under an agreement, and not charged an amount more than is provided for in the Regulation, or if no amount is provided for, not charging more than a reasonable amount.

The licensee has failed to ensure that residents were not charged for anything, except in accordance with the following: 4. Despite paragraph 3, a resident shall not be charged for anything that the regulations provide is not to be charged.

Under 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:

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. Except in accordance 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.

Under Long Term Care-Service Accountability Agreement (L-SAA) Policy: LTCH Required Goods, Equipment, Supplies and Services, Date: 2010-07-01 indicated under section 2.1.12 Other Supplies and Equipment:

The licensee must provide the following goods, equipment, supplies and services to long-term care
(LTC) home residents at no charge, other than the accommodation charge payable under the LongTerm Care Homes Act, 2007 (LTCHA), using the funding the licensee receives from the Local Health Integration Network under the Local Health System Integration Act, 2006 (LHSIA) or the Minister under the LTCHA or accommodation charges received under the LTCHA. The list of the goods, equipment, supplies and services the licensee must ensure is provided to residents, where not covered under another government program, is non-exhaustive and does not include a complete list of the goods, equipment, supplies and services the licensee must ensure is provided to residents to meet the requirements under O. Reg. 79/10. The classification of an expenditure into a particular funding envelope is determined in accordance with the Ministry's policy for classifying eligible expenditures and is not reflected in the order or organization of the following list:
2.1.12 Other Supplies and Equipment-Other supplies and equipment including but

not limited to:
c. Equipment and supplies to ensure resident safety
d. Equipment and supplies to prevent resident falls

Review of the Progress Notes for resident #003, indicated that on an identified date in March 2017, a referral was sent to the Physiotherapist (PT) for a safety device for the resident. The PT contacted the resident's Family Member providing information to purchase the safety device. The PT documented that he/she emailed the Family Member of the resident, the product information cost. The Family Member agreed to the purchase of the safety device.

In a telephone interview with resident #003's Family Member, by Inspector #607 on two identified dates in June 2017, the Family Member indicated being sent an email by the PT, indicating resident #003 needed a safety device, due to ongoing falls. The Family Member further indicated being advised by the PT, that it was the family's responsibility to purchase the safety device. The Family Member indicated having purchased a total of two of the safety device for the resident.

In an interview with the PT, by Inspector #607, on an identified date in June 2017, indicated when a resident has fallen and requires a safety device, it is the family's responsibility to purchase the device for the resident. The PT indicated resident #003 required the device to minimize injury related to ongoing falls. Further interview with the PT on an identified date in June 2017, indicated that no other family members within the home have been asked to purchase any safety or fall prevention devices.

During an interview with the DOC, by Inspector #607 on an identified date in June 2017, The DOC indicated the device resident #003 uses, is a safety device that aids in the minimization of the resident injuries related to falls.

During an interview with the Administrator, by Inspector #607, on an identified date in June 2017, indicated the purchase of resident #003's safety device by a Family Member was an isolated incident. In addition, the Administrator indicated he/she had asked why was the Family Member paying for the device, and indicated by this time, the Family Member had already purchased and brought the device in, for resident #003. The Administrator indicated the home do not usually ask families to pay for any safety or fall prevention devices. (607)

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

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

Aug 08, 2017

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

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

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 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

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

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 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

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 19 day of July 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JULIET MANDERSON-GRAY

Service Area Office /
Bureau régional de services : Ottawa