



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**Long-Term Care Homes Division
Long-Term Care Inspections Branch**

**Division des foyers de soins de
longue durée
Inspection de soins de longue durée**

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du
Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

Public Copy/Copie du public

Report Date(s) / Date(s) du rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 1, 2018	2018_737640_0014	008071-18	Complaint

Licensee/Titulaire de permis

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

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

Extendicare Brampton
7891 McLaughlin Road BRAMPTON ON L6Y 5H8

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

HEATHER PRESTON (640)

Inspection Summary/Résumé de l'inspection



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

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

This inspection was conducted on the following date(s): May 7, 8, 9, 10, 11, 14, 15, 16, 22 and 23, 2018

This inspection was conducted concurrently with Critical Incident Inspection #2018_737640_0013 and Complaint Inspection #2018_737640_0012

During this inspection the following complaints were inspected;

**Log #014063-17 related to complaint regarding convalescent care and,
Log #008071-18 related to complaint regarding refusal to admit**

During the course of the inspection, the inspector(s) spoke with Residents, Family members, Substitute Decision Makers (SDM), Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Physiotherapy (PT), Clinical Resource Nurse, Resident Assessment Instrument (RAI) Coordinator, Wound Care Nurse, Fall Prevention Lead, Behaviour Support Ontario (BSO) Lead, Director of Care (DOC), the Administrator and Central West Local Health Integration Network (CW LHIN).

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

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

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



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

Specifically failed to comply with the following:

- s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,**
- (a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).**
 - (b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).**
 - (c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).**

Findings/Faits saillants :



1. The licensee failed to take into account the assessments and information under subsection 43 (6), and approve an applicant's admission to the home unless: a) the home lacked the physical facilities necessary to meet the applicant's care requirements and b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements.

As a result of the complaint inspection related to refusal of admission of applicant #002, the Long-Term Care Home (LTCH) Inspector requested a copy of the home's refusal to admit letter sent to the applicant. The Director of Care (DOC), did not have a copy of the letter but did obtain a copy from their contact at Central West Local Health Integration Network (CW LHIN).

Applicant #002 had been deemed eligible for admission to long-term care by a Placement Coordinator at the CW LHIN and had applied to Extendicare Brampton for admission in January 2018.

On a specified date in January 2018, the Director of Care of the home sent a letter to the applicant, stating "the home lacked the physical facilities necessary to meet the applicant's care requirements and the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements."

The DOC did not have a file or copy of the original application package and was unable to provide detailed explanation of the refusal as to how the physical facility and staff expertise were unable to meet the needs of the applicant.

During an interview with the DOC, they acknowledged that, at the time of the application, the home had a full-time Behaviour Support Ontario (BSO) Personal Support Worker (PSW) and part-time BSO RPN. The home also had a fully functional "WanderGuard" alarm system in place throughout the home.

The LTCH Inspector reviewed with the DOC that the home had access to High Intensity Needs (HIN) funding from the Ministry of Health and Long Term Care (MOHLTC) wherein funds could be made available for staffing needs related to the care of the applicant.

The DOC acknowledged the refusal to admit applicant #002, however was not able to validate the legislative rationale for the refusal used in the letter. [s. 44. (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 the licensee must take into account the assessments and information under subsection 43 (6), and approve an applicant's admission to the home unless: a) the home lacked the physical facilities necessary to meet the applicant's care requirements and b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :



1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was investigated and resolved where possible, and a response that complied with paragraph 3 provided within 10 business days of the receipt of the complaint.

Resident #008 was admitted to the home for a period of time in May 2017, following surgery. The resident presented several complaints to the licensee regarding the operation of the program.

The home's policy "Complaints and Customer Service", policy #RC-09-01-04 with a revised date of April 2017, directed staff to comply with relevant regulatory requirements regarding concerns/complaints. All materials related to the investigation were to be kept in one file for future retrieval and quality improvement auditing.

The policy directed staff to provide a written response at the conclusion of the investigation to include what the home had done to resolve the complaint and if the complaint was unfounded, the reasons why this conclusion was reached. The policy noted, that in Ontario, complaints/concerns brought forward by a resident were to be investigated, resolved (where possible) and a written response signed by the Administrator provided to the complainant within 10 business days.

On a specified date in June 2017, the Director of Care (DOC) called the complainant. The resident followed up with some specific concerns.

The complainant contacted the Ministry of Health and Long Term Care to report their concerns about the program as above and to state their issues were not responded to.

The Long-Term Care Homes (LTCH) Inspector requested from the DOC, all correspondence including email messages that had involved the complainant. At the time of the complaints, the DOC was acting as the Administrator. The DOC provided one email message from the complainant which was not the initial message of complaint nor was it a written response to the complaint(s).

During an interview with the DOC, they acknowledged they had not managed the complaints from resident #008 as required by the home's policy and the legislation. [s. 101. (1) 1.]



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

Issued on this 27th day of June, 2018

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

Original report signed by the inspector.