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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 14, 2020	2020_791739_0005	001375-20	Complaint

Licensee/Titulaire de permis

Babcock Community Care Centre Inc.
196 Wellington Street P.O. Box 190 Wardsville ON N0L 2N0

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

Babcock Community Care Centre
196 Wellington Street P.O. Box 190 Wardsville ON N0L 2N0

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

JULIE DALESSANDRO (739)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 10, 2020.

The following intake was inspected during this Complaint Inspection:
Log #001375-20 / IL-73873-LO related to the discharge of a resident

During the course of the inspection, the inspector(s) spoke with a Local Health Integration Network Placement Manager and Placement Coordinator as well as the home's Director of Care and Administrator.

During the course of this inspection the inspector(s) also conducted record reviews relevant to this inspection.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 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. 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 :

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

Specifically, the licensee has failed to ensure that before discharging a resident under subsection 145 (1), the licensee shall: a) in collaboration with the appropriate placement coordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident and b) provide a written notice to the resident 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).

A complaint was received by the Ministry of Long-Term Care Info Line regarding the

discharge of resident #001 from Babcock Community Care Centre. The complainant stated that the home did not comply with the Long-Term Care Home regulations related to the requirements of the licensee before resident #001 was discharged. Specifically, there was no collaboration with the placement co-ordinator to make alternative arrangements for the accommodation required by the resident.

(A) Record review of resident #001's health record was completed. The resident had incidents of responsive behaviours throughout their stay in the home, but those behaviours significantly escalated during a specific month.

Record review of the resident's progress notes in Point Click Care indicated that the home received a call from another health care facility asking if they would be able to take resident #001 back to the home. The home advised the caller that they were not able to safely handle resident #001's behaviours and it had been decided that they had been discharged from the home.

During an interview with Administrator #103 and Director of Care (DOC) #104, Inspector #739 asked if the home had collaborated with the appropriate Local Health Integration Network (LHIN) placement coordinator and had made alternative arrangements for accommodating resident #001. Administrator #103 indicated that they, along with DOC #104 and the home's physician #102, had discussed discharging the resident and stated that there had not been any collaboration with the LHIN prior to resident #001's discharge.

During an interview with LHIN placement coordinator #101, they stated that they had been informed during a phone conversation with the home's DOC #104, five days after the resident was discharged, that resident #001 had been transferred to another health care facility and discharged from the home due to behaviours.

The home had failed to ensure that, in collaboration with the appropriate placement coordinator and other health service organizations, they had made alternative arrangements for the accommodation, care and secure environment required by resident #001 prior to discharge.

(B) Record review of the resident's clinical chart in Point Click Care, under the 'census tab', indicted that resident #001 was discharged from the home on a specific date.

Record review of the discharge letter indicated that the letter was addressed to resident

#001's substitute decision maker, stating that resident #001 was being discharged from the home, however the home was unable to produce a letter that had been addressed to resident #001 regarding the reason they had been discharged.

DOC #104 acknowledged that the home did not meet the legislative requirement for discharge of a resident. Specifically, the home did not provide a written notice to resident #001 setting out a detailed explanation of the supporting facts that justified the home's decision to discharge them.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that before discharging a resident under subsection 145 (1), the licensee shall: a) in collaboration with the appropriate placement coordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident and b) provide a written notice to the resident 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, to be implemented voluntarily.

Issued on this 14th day of February, 2020

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

Original report signed by the inspector.