Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
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Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 1, 2017	2017_605213_0018	019277-17, 019784-17, 021147-17	Complaint

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE WOODSTOCK ON N4S 3V9

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

CAMBRIDGE COUNTRY MANOR
3680 SPEEDSVILLE ROAD R R 31 CAMBRIDGE ON N3H 4R6

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

RHONDA KUKOLY (213)

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): August 29, 30, 31 and September 1, 2017

This complaint inspection was completed off site and is related to three complaints, 019277-17, 019784-17 and 021147-17, all regarding an illegal discharge of a resident.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing, a Registered Nursing staff member, the Integrated Patient Services Manager with the Waterloo-Wellington Local Integration Health Network, a representative from the Advocacy Centre for the Elderly and a family member; all by phone.

The Inspector also reviewed health records sent by fax.

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)**
- **0 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 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 a resident was discharged under subsection 145(1), there was b) collaboration with the appropriate placement coordinator and other health service organizations to make alternative arrangements for the accommodation, care and secure environment required by the resident, c) that the resident and the resident's substitute decision maker, were kept informed and given opportunity to participate in the discharge planning and that her wishes were taken into consideration and d) that a written notice was provided to the resident, and resident's substitute decision maker, that set out a detailed explanation of the supporting facts, as they related both to the home and to the resident's condition and requirements for care that justified the licensee's reason for discharge.

Complaints were received by the Ministry of Health and Long Term Care from the Integrated Patient Services Manager from Waterloo-Wellington Local Integration Health Network (LHIN), a resident substitute decision maker, and the Advocacy Centre for the Elderly related to the illegal discharge of a resident from Cambridge Country Manor.

Phone interviews were conducted with the Integrated Patient Services Manager (IPSM)

from the Waterloo-Wellington Local Integration Health Network (LHIN), a resident's substitute decision maker (SDM), a representative of the Advocacy Centre for the Elderly, and the Director of Nursing and a Registered Nursing staff member at Cambridge Country Manor. Record reviews were completed of the resident's Hospital Minimum Data Set Home Care, a Psychogeriatric Resource Consultant (PRC) Consultation Notes, and emails between the home and the IPSM.

In phone interviews with the resident's SDM and the IPSM, the resident's SDM reported that the resident experienced an episode of responsive behaviours. The home contacted the resident's SDM by phone on two occasions and advised them that the resident was discharged and that they were to remove the resident's belongings. The resident's SDM stated that they had not received written notification of discharge from the home or the licensee. The SDM had not removed the resident's belongings from the home as the LHIN had advised them that the resident was not discharged.

In a phone interview with the Director of Nursing (DON) and a Registered Nursing staff of the home, the DON confirmed that they that contacted the resident's SDM and advised the family that the resident was discharged and to remove the resident's belongings. When asked if the resident's attending physicians were involved in the decision to discharge the resident, the DON replied no, neither physician had been involved. When asked if the resident or the SDM had received written notification of discharge from the home, the DON confirmed they had not.

The licensee failed to ensure that before a resident was discharged under subsection 145(1), there was collaboration with the appropriate placement coordinator and other health service organizations to make alternative arrangements for the accommodation, care and secure environment required by the resident, that the resident and the resident's substitute decision maker, were kept informed and given opportunity to participate in the discharge planning and that her wishes were taken into consideration and that a written notice was provided to the resident, and resident's substitute decision maker, that set out a detailed explanation of the supporting facts, as they related both to the home and to the resident's condition and requirements for care that justified the licensee's reason for discharge when the home verbally advised the substitute decision maker of a resident that the resident was discharged from the home on two occasions.

The severity of this non-compliance is a potential for harm and the scope is wide spread with one out of one resident being affected. The home does not have a history of non-compliance in this subsection of the legislation. [s. 148. (2)]

Additional Required Actions:

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

Issued on this 15th day of September, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	RHONDA KUKOLY (213)
Inspection No. / No de l'inspection :	2017_605213_0018
Log No. / No de registre :	019277-17, 019784-17, 021147-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 1, 2017
Licensee / Titulaire de permis :	CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED 264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	CAMBRIDGE COUNTRY MANOR 3680 SPEEDSVILLE ROAD, R R 31, CAMBRIDGE, ON, N3H-4R6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Heather Richardson

To CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED, 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 :

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

Order / Ordre :

The Licensee shall:
a) Put the resident, if the resident or substitute decision maker so chooses, into a private room if and when one is available.

b) Ensure all appropriate assessments are completed for the resident including screening protocols, assessment and identification of behavioural triggers that may result in responsive behaviours.

c) Ensure that recommendations and transition plans from applicable professional resources and the Psychiatric Resource Consultant, as well as the results of assessments completed; including written strategies, techniques and interventions to prevent, minimize or respond to responsive behaviours, and to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours; are included in the resident's plan of care.

d) Ensure that care and services are provided as per the resident's assessed needs, including one on one staff support if deemed required.

e) Refrain from discharging the resident under O. Reg 79/10 s. 145(1) unless the licensee has first complied with O. Reg 79/10 s.148. Specifically, if the resident is to be discharged, the licensee must:
i. 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 resident #001;
ii. Ensure the resident, the substitute decision maker and any person either of them may direct is kept informed and given the opportunity to participate in the discharge planning and that the resident's wishes are taken into consideration; and
iii. Provide a written notice to the resident setting out a detailed explanation of the supporting facts, as they relate to both the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge this resident, before the date the discharge takes effect.

f) Refrain from discharging the resident under O. Reg 79/10 s. 145(1) unless the licensee has first complied with O. Reg 79/10 s.145(2). Specifically, if the resident is to be discharged from the home while in hospital or absent from the home, the licensee must be informed by the resident's attending physician in hospital or a registered nurse in the extended class in the hospital.

g) The home should apply for the Ministry of Health and Long-Term Care High Intensity Needs Funding to support the resident living in preferred accommodation if needed and for one on one staffing if needed.

Grounds / Motifs :

1. The licensee has failed to ensure that before a resident was discharged under subsection 145(1), there was b) collaboration with the appropriate placement coordinator and other health service organizations to make alternative arrangements for the accommodation, care and secure environment required by the resident, c) that the resident and the resident's substitute decision maker, were kept informed and given opportunity to participate in the discharge planning and that her wishes were taken into consideration and d) that a written notice was provided to the resident, and resident's substitute decision maker, that set out a detailed explanation of the supporting facts, as they related both to

the home and to the resident's condition and requirements for care that justified the licensee's reason for discharge.

Complaints were received by the Ministry of Health and Long Term Care from the Integrated Patient Services Manager from Waterloo-Wellington Local Integration Health Network (LHIN), a resident substitute decision maker, and the Advocacy Centre for the Elderly related to the illegal discharge of a resident from Cambridge Country Manor.

Phone interviews were conducted with the Integrated Patient Services Manager (IPSM) from the Waterloo-Wellington Local Integration Health Network (LHIN), a resident's substitute decision maker (SDM), a representative of the Advocacy Centre for the Elderly, and the Director of Nursing and a Registered Nursing staff member at Cambridge Country Manor. Record reviews were completed of the resident's Hospital Minimum Data Set Home Care, a Psychogeriatric Resource Consultant (PRC) Consultation Notes, and emails between the home and the IPSM.

In phone interviews with the resident's SDM and the IPSM, the resident's SDM reported that the resident experienced an episode of responsive behaviours. The home contacted the resident's SDM by phone on two occasions and advised them that the resident was discharged and that they were to remove the resident's belongings. The resident's SDM stated that they had not received written notification of discharge from the home or the licensee. The SDM had not removed the resident's belongings from the home as the LHIN had advised them that the resident was not discharged.

In a phone interview with the Director of Nursing (DON) and a Registered Nursing staff of the home, the DON confirmed that they that contacted the resident's SDM and advised the family that the resident was discharged and to remove the resident's belongings. When asked if the resident's attending physicians were involved in the decision to discharge the resident, the DON replied no, neither physician had been involved. When asked if the resident or the SDM had received written notification of discharge from the home, the DON confirmed they had not.

The licensee failed to ensure that before a resident was discharged under subsection 145(1), there was collaboration with the appropriate placement coordinator and other health service organizations to make alternative

arrangements for the accommodation, care and secure environment required by the resident, that the resident and the resident's substitute decision maker, were kept informed and given opportunity to participate in the discharge planning and that her wishes were taken into consideration and that a written notice was provided to the resident, and resident's substitute decision maker, that set out a detailed explanation of the supporting facts, as they related both to the home and to the resident's condition and requirements for care that justified the licensee's reason for discharge when the home verbally advised the substitute decision maker of a resident that the resident was discharged from the home on two occasions.

The severity of this non-compliance is a potential for harm and the scope is wide spread with one out of one resident being affected. The home does not have a history of non-compliance in this subsection of the legislation. [s. 148. (2)] (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 07, 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

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
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

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

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 1st day of September, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : RHONDA KUKOLY

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