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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 29, 2016	2016_303563_0025	016108-16	Critical Incident System

Licensee/Titulaire de permis

CRAIGWIEL GARDENS
221 MAIN STREET R. R. #1 AILSA CRAIG ON N0M 1A0

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

CRAIGHOLME
221 MAIN STREET R. R. #1 AILSA CRAIG ON N0M 1A0

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

MELANIE NORTHEY (563), CHRISTINE MCCARTHY (588)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 3, 16 and July 27, 2016

This Critical Incident was related to discharging a resident. This inspection was completed concurrently with Complaint Log #017631-16 - IL45050-LO.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Health and Safety Officer, the Patient Care Manager-Community Care Access Center, the Behaviour Supports Ontario Personal Support Worker, two Registered Practical Nurses, three Personal Support Workers, one resident, and one family member.

The inspector(s) also reviewed the home's investigation notes, relevant documentation, clinical records and plan of care for the identified resident.

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)**
- **0 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	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. 145. When licensee may discharge

Specifically failed to comply with the following:

s. 145. (1) A licensee of a long-term care home may discharge a resident if the licensee is informed by someone permitted to do so under subsection (2) 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).

Findings/Faits saillants :

1. The licensee failed to show that the resident's requirements for care had changed and that, as a result, the home could not provide a sufficiently secure environment to ensure safety of persons who come into contact with the resident, before discharging.

Record review of the progress notes in PointClickCare (PCC) stated that there was an incident where a resident demonstrated responsive behaviours directed at the registered staff member. Four days later the resident was discharged.

Record review of the progress notes in PCC over a five month period demonstrated documentation related to multiple behaviours exhibited by the resident, however the progress notes also demonstrated an absence of further aggressive behaviours between the day of the incident and the day of discharge.

The DOC shared that the resident was not aggressive the week after the incident.

Documentation in the progress notes demonstrated that the interventions in place were successful, and the resident did not have another incident. There were no other incidents after the initial incident. (536)

The home was unable to demonstrate that the interventions they had in place were not managing the resident's behaviours and that discharge was the only option to ensure the safety of the resident and the persons who come into contact with the resident. [s. 145. (1)]

WN #2: 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 there was collaboration with the appropriate placement co-ordinator and other health service organizations, to make alternative arrangements for the accommodation, care and secure environment required by the resident.

Record review of the progress notes stated the resident was being discharged from the facility. Discharge paper was served to the resident by the Executive Director as the resident was leaving the home.

The Patient Care Manager at Southwest Community Care Access Center (PCM-SWCCAC) was notified by the home after the resident was discharged. The PCM-SWCCAC said that there was no contact from the home to CCAC after the incident until the day of discharge and that CCAC had last been in contact with the home a year prior related to this resident. The PCM-SWCCAC stated the home did not collaborate with a CCAC placement coordinator to make alternate arrangements for accommodation, care and secure environment required by the resident before the home discharged to hospital.

c) The licensee has failed to ensure that before discharging a resident that the resident and any person the resident may direct was kept informed and given an opportunity to participate in the discharge planning and that his or her wishes were taken into consideration.

Record review of a progress note in PCC stated that staff had left a message for the resident's family member indicating that the resident had been discharged from the home after the resident had already left. The family member was visiting the resident the day of the discharge and was notified then that the resident was discharged and would not be returning.

The family member shared that there was a phone message on their home phone from the Director of Care (DOC) which revealed the discharge after the fact.

The DOC shared that the resident and the family member were not made aware of the plan to discharge prior to the discharge.

The home did not ensure that the resident or the family member were kept informed or given an opportunity to participate in the discharge planning and that his or her wishes were taken into consideration.

(d) Before discharging a resident, the licensee has failed to provide a written notice to the resident and any person he 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.

Record review of the discharge letter addressed to the resident did not 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.

The family member of the resident shared that they never received information related to the discharge or a written notice justifying the discharge from the home, which detailed the facts in relation to the resident's condition or requirements of care. The resident shared that they were never notified or provided any documentation that there had been any change in their condition or care that required any intervention.

The written notice provided to the resident and the resident's family member did not 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 justify the licensee's decision to discharge the resident. [s. 148. (2)]

Issued on this 17th day of August, 2016

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

Original report signed by the inspector.