Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District
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Original Public Report

Report Issue Date: August 19, 2024

Inspection Number: 2024-1628-0001

Inspection Type:
Complaint

Licensee: The Corporation of the City of Guelph

Long Term Care Home and City: The Elliott Long Term Care Residence, Guelph

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: July 25, 29-31, August 1, 2024, and offsite on July 26, 2024.

The following Complaint intakes were inspected:
· Intakes: #00121349, #00121687, and #00121762 related to a resident's discharge from the home.
· Intake: #00122253 related to an allegation of resident abuse.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Responsive Behaviours

Prevention of Abuse and Neglect
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: INVOLVEMENT OF RESIDENT, ETC.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee failed to ensure that a resident's Power of Attorney (POA) was given an opportunity to participate in the development and implementation of their plan of care.

Rationale and Summary

A resident was admitted to the home with POA documentation that included two POAs for care.

The second POA was requested to be the main contact to participate in the resident's plan of care. The second POA was not contacted for a six month period, including when there was a care conference held about the resident.

When the second POA was not given an opportunity to be involved with the development and implementation of the resident's plan of care, the resident was at increased risk of ineffective care planning, as well as miscommunication with their desired POAs.

Sources: Resident's clinical records; Interviews with the resident, POA, Assistant Director of Care (ADOC), Director of Care (DOC), as well as other staff. [000734]

WRITTEN NOTIFICATION: WHEN LICENSEE MAY DISCHARGE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 157 (1)
When licensee may discharge
s. 157 (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.

The licensee failed to comply with section 157 (1) of O. Reg. 246/22, whereby the licensee discharged a resident from the Long-Term Care Home (LTCH) while absent from the home, without being informed by the attending physician 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. 246/22, s. 157 (2) (b) states that for the purposes of subsection (1), the licensee shall be informed by, in the case of a resident who is absent from the home, the resident's physician or a registered nurse in the extended class attending

the resident.

Rationale and Summary

A resident was discharged from the home while they were on a psychiatric absence.

The information provided to the licensee by the physician attending to the resident while they were on a psychiatric absence, did not indicate 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.

By discharging the resident from the LTCH, the resident remained at the facility they were admitted to during their psychiatric absence.

Sources: Resident's clinical health records; Interviews with the resident's SDM, the facility's physician, and social worker, the home's DOC, and other staff. [653]

WRITTEN NOTIFICATION: REQUIREMENTS ON LICENSEE BEFORE DISCHARGING A RESIDENT

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (2)
Requirements on licensee before discharging a resident
s. 161 (2) Before discharging a resident under subsection 157 (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 their 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.

The licensee failed to ensure that each requirement outlined in O. Reg. 246/22, s. 161 (2) were met prior to discharging a resident from the LTCH.

Summary and Rationale

A resident was discharged from the home while they were on a psychiatric absence.

There were no collaborative discussions from the LTCH, the facility, and the resident's SDM regarding any discharge planning or alternatives for the resident prior to discharge.

The SDM was not provided with a written notice setting 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 decision to discharge the resident.

By not complying with each requirement outlined in O. Reg. 246/22, s. 161 (2), the

SDM's wishes were not taken into consideration regarding the discharge process, and the resident remained at the facility they were admitted to during their psychiatric absence

Sources: Resident's clinical health records; Interviews with the resident's SDM, the facility's physician, and social worker, the home's DOC, and other staff. [653]