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
Jun 2, 2017	2017_448155_0003	003495-17	Complaint

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF GREY
206 Toronto Street MARKDALE ON N0C 1H0

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

GREY GABLES HOME FOR THE AGED
206 TORONTO STREET SOUTH MARKDALE ON N0C 1H0

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

SHARON PERRY (155)

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 9, 10, 14, 15, 16, and 17, 2017.

This complaint inspection was regarding a discharge of a resident. Telephone interviews were conducted on February 21, 28, March 6 and March 22, 2017.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Resident and Family Services Manager, Social Worker from alternate facility, Manager from alternate facility, Attending Physician from alternate facility, and family.

The inspector also reviewed relevant clinical records and letter of discharge.

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

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. (2) For the purposes of subsection (1), the licensee shall be informed by,
(a) in the case of a resident who is at the home, the Director of Nursing and Personal Care, the resident's physician or a registered nurse in the extended class attending the resident, after consultation with the interdisciplinary team providing the resident's care; or O. Reg. 79/10, s. 145 (2).
(b) 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. O. Reg. 79/10, s. 145 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the long-term care home discharged a resident when the licensee was 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. (2) For the purposes of subsection (1), the licensee shall be informed by,
(b) in the care of a resident who is absent from the home, the resident's physician or a registered nurse in the extended class attending the resident.

Record review showed that a resident was sent from the home to another health care facility for assessment on an identified date.

During an interview with the Administrator and Director of Care they told the inspector that the resident went to another health care facility for assessment for identified reasons.

The identified resident was to return to the home on an identified date.

On an identified date the family of the identified resident was notified that the resident was not going to be readmitted to the home.

During an interview with the attending physician for the identified resident at the other health care facility, they shared that the resident was ready for discharge back to Grey Gables.

The licensee discharged the identified resident when they were not permitted to do so as the attending physician for the resident did not inform Grey Gables that the resident's requirements for care had changed and as a result, the home could not provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come into contact with the resident.

During this inspection this non-compliance was found to have a severity level of minimum risk (level 1), the scope was isolated (level 1), and there was unrelated non-compliance issued in the last three years (level 2). [s. 145. (2) (b)]

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 failed to ensure that before discharging a resident under subsection 145 (1) (the resident's requirements for care had changed and as a result, the home could not provide a sufficiently secure environment to ensure the safety of the resident of the safety of persons who come into contact with the resident), the licensee failed to ensure,
(a) 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; and
(c) the resident and the resident's substitute decision-maker, if any, and any person either of them may direct, was kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration.

The Administrator and Director of Care shared that they advised an identified staff member at another health care facility that they could not re-admit the identified resident

on the planned date.

During an interview with the attending physician for the identified resident at the other health care facility, they shared that the resident was ready for discharge back to Grey Gables.

The Director of Care shared that they contacted the resident's power of attorney on an identified date and informed them that they could not readmit the resident at this time and the bed would be released on an identified date.

During interviews with the Administrator, Director of Care and Resident and Family Services Manager they all shared that the Community Care Access Centre was not advised of the discharge of the identified resident until the bed vacancy form was submitted.

The licensee failed to ensure that before discharging a resident under subsection 145 (1) that alternatives to discharge had been considered and, where appropriate, tried; that collaboration with the appropriate placement co-ordinator and other health service organizations was done; and that the resident's power of attorney was kept informed and given an opportunity to participate in the discharge planning and that his or her wishes were taken into consideration.

During this inspection this non-compliance was found to have a severity level of minimum risk (level 1), the scope was isolated (level 1), and there was unrelated non-compliance issued in the last three years (level 2). [s. 148. (2)]

Issued on this 22nd day of June, 2017

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

Original report signed by the inspector.