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
May 10, 2016	2015_248214_0025	H-002887-15	Complaint

Licensee/Titulaire de permis

HENLEY HOUSE LIMITED
200 RONSON DRIVE SUITE 305 TORONTO ON M9W 5Z9

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

THE HENLEY HOUSE
20 Ernest Street St. Catharines ON L2N 7T2

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

CATHY FEDIASH (214)

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): September 3, 4, 9, 16, 17, 2015 and November 5, 2015.

Please note: This inspection was conducted in relation to a complaint made on behalf of resident #100's substitute decision maker (SDM) in regards to sufficient notice of the resident's discharge not being provided. It was identified during this inspection that the resident was admitted to the home with a high level of care needs and over time, their condition declined which resulted in a higher level of care needs. The resident's SDM requested that the resident remain at an identified level of code status while they resided at the home. The home invited the SDM to a care conference on an identified date in 2014, to discuss the resident's care; however; the SDM declined to attend. The home engaged with external consultant's in their decision to discharge the resident. Two days before the resident was discharged, the home's interdisciplinary team including the Director of Care (DOC) met and agreed that for the safety of the resident, the home could not provide safely, the level of care required for the resident. The day before the resident was discharged, the licensee received a legal opinion to discharge the resident for safety and the home's Administrator was made aware that the discharge process had begun. The next day the resident was discharged from the home and the resident's SDM was made aware of the resident's discharge on this day just prior to the resident leaving the home.

During the course of the inspection, the inspector(s) spoke with the Administrator; Acting Director of Care (ADOC); Director, Clinical Services; Managing Director - LTC Operations and the SDM's lawyer. During the course of this inspection, the inspector reviewed the resident's clinical records, external consultant documentation and the home's documentation.

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)
2 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A review of resident #100's clinical records indicated that the resident was admitted to the home on an identified date in 2012. The clinical records indicated that the resident was admitted with a specialized medical requirement, had an identified level of code status and had an overall high level of care needs. A review of the resident's clinical records as well as external consultant's documentation and the home's documentation was conducted for an identified period of time and indicated that the resident's condition declined over time since their admission. On an identified date, the home had an independent medical review conducted for resident #100. An interview with the Managing Director – LTC Operations confirmed that the independent medical review was conducted to determine if the resident's care needs could be met in their current long term care home setting. The Managing Director – LTC Operations confirmed that the resident's SDM had not been made aware of the independent medical review that was conducted. The SDM was not given the opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)]

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 all resident's, the resident's substitute decision-maker, if any, and any other persons designated by any resident or their substitute decision-maker are given an opportunity to participate fully in the development and implementation of the residents plan of care, to be implemented voluntarily.

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. (1) Except in the case of a discharge due to a resident's death, every licensee of a long-term care home shall ensure that, before a resident is discharged, notice of the discharge is given to the resident, the resident's substitute decision-maker, if any, and to any other person either of them may direct,
(a) as far in advance of the discharge as possible; or O. Reg. 79/10, s. 148 (1).
(b) if circumstances do not permit notice to be given before the discharge, as soon as possible after the discharge. O. Reg. 79/10, s. 148 (1).

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 a resident was discharged, notice of the discharge was given to the resident, the resident's substitute decision-maker, if any, and to any other person either of them may direct as far in advance of the discharge as possible.

A review of resident #100's clinical records indicated that the resident was admitted to the home on an identified date in 2012. The clinical records indicated that the resident was admitted with a specialized medical requirement, had an identified level of code

status and had an overall high level of care needs. A review of the resident's clinical records; external consultant's documentation and the home's documentation was conducted for an identified period of time. A review of this documentation including interviews with the Director, Clinical Services, indicated that the resident's condition declined over time since their admission. An interview with the Director, Clinical Services and review of the home's documentation indicated that on an identified date in 2014, the home attempted to engage the SDM to begin discussions on discharge planning for the resident through a care conference with the team and the Medical Doctor; however, the SDM refused to attend. On an identified date, the home had an independent medical review conducted for resident #100. An interview with the Managing Director – LTC Operations on an identified date in 2015, confirmed that the independent medical review was conducted to determine if the resident's care needs could be met in their current long term care home setting. According to the home's documentation on an identified date in 2015, following the completion of the independent medical review, the home's interdisciplinary team consisting of the DOC, the Administrator and the Managing Director – LTC Operations met and reviewed the verbal recommendation from the independent medical review. The interdisciplinary team agreed that for safety reasons the resident's care needs could not be met in their current long term care home setting. The home confirmed that the decision was made to discharge the resident on an identified date in 2015, but the SDM was not notified until two days later. A review of the resident's clinical records and the home's documentation indicated that the resident was discharged from the home on an identified date in 2015 and that the resident's SDM was made aware of the resident's discharge just prior to the resident leaving the home. [s. 148. (1) (a)]

2. The licensee failed to ensure that before discharging a resident under O.Reg.79/10, s.145 (1), they provided 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 justified the licensee's decision to discharge the resident.

A review of resident #100's clinical record's indicated that the resident was admitted to the home on an identified date in 2012. The clinical records indicated that the resident was admitted with a specialized medical requirement, had an identified level of code status and had an overall high level of care needs. A review of the resident's clinical records as well as external consultant's documentation and the home's documentation was conducted for an identified period of time and indicated that the resident's condition

declined over time since their admission. According to the home's documentation on an identified date in 2015, following the completion of an independent medical review, the home's interdisciplinary team consisting of the DOC, the Administrator and the Managing Director – LTC Operations met and reviewed the verbal recommendation from the independent medical. The interdisciplinary team agreed that for safety reasons the resident's care needs could not be met in their current long term care home setting. A review of the resident's clinical records and the home's documentation indicated that the resident was discharged from the home on an identified date in 2015.

A review of the resident's Power of Attorney (POA) papers indicated that they had two SDMs who were jointly appointed for the resident's care and financial decisions. A review of the discharge letter dated on an identified date in 2015, indicated the home had 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 explained the home's decision to discharge the resident; however, the home had provided this written notice to the resident and only one of the resident's SDMs. An interview with the Director, Clinical Services on an identified date in 2015, indicated that the second SDM had verbalized to the home on an identified date in 2014, that they only wished to be involved in the resident's financial decisions. As directed in Ontario Regulation 79/10, r.256(1)(b), which states, "A long-stay resident shall pay the amount charged for accommodation under either paragraph 1 or 2 of subsection 91(1) of the Act for a full day, for the day the resident is discharged from the home". O. Reg. 79/10, [s.256 (1)]. This direction would have impacted on the resident's finances upon their discharge. An interview with the Director, Clinical Services on an identified date in 2015, confirmed that the home had not informed the resident's second SDM of the resident's discharge which would include any financial decisions related to their discharge from the home. [s. 148. (2)]

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 a resident is discharged, notice of the discharge is given to the resident, the resident's substitute decision-maker, if any, and to any other person either of them may direct as far in advance of the discharge as possible and that before discharging a resident under O.Reg.79/10, s.145 (1), they 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 justified the licensee's decision to discharge the resident, to be implemented voluntarily.

Issued on this 4th day of July, 2016

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

Original report signed by the inspector.