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
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: May 9, 2024

Inspection Number: 2024-1142-0002

Inspection Type:
Complaint

Licensee: 2063412 Ontario Limited as General Partner of 2063412 Investment LP

Long Term Care Home and City: Creedan Valley Community, Creemore

Lead Inspector	**Inspector Digital Signature**
Kim Byberg (729)	Kimberly Byberg Digitally signed by Kimberly Byberg Date: 2024.05.23 09:25:14 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 16 - 19, 22, 23, and 29, 2024.
The inspection occurred offsite on the following date(s): April 22, and 24, 2024.

The following intake(s) was inspected in this complaint inspection:
- Intake: #00113390 - related to the discharge of a resident from the long-term care home.

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

Infection Prevention and Control
Responsive Behaviours
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive behaviours

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee failed to ensure that when a resident exhibited responsive behaviours, actions were taken to respond to their needs, including assessments, reassessments and interventions, and that the residents' responses to the interventions were documented.

Summary and Rationale
Upon admission to the home, a resident was prevented from participating in specified activities. This triggered the resident to have responsive behaviours. Interventions were implemented to respond to the resident's behaviours, however, these interventions further escalated the resident's behaviours.

The home did not complete assessments to determine if it was safe or unsafe for the resident to participate in specified activities. Additionally, the home did not complete any reassessments when they identified that interventions put in place to respond to the resident's responsive behaviours were ineffective.

Not allowing the resident to participate in specified activities made them feel like

they were in jail. The limitations triggered an escalation in behaviours leading to altercations with staff and others.

Sources: Home and Community Care Support Services (HCCSS) referral, progress notes, care plan, interview with the resident, and Assistant Director of Care (ADOC). [729]

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 (2) (b)
When licensee may discharge
s. 157 (2) For the purposes of subsection (1), the licensee shall be informed by,
(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.

The licensee failed to ensure that when a resident was admitted to the hospital, the physician attending to the resident was the individual who discharged them from the long-term care home.

Summary and Rationale
A resident was sent to the hospital due to an escalation of responsive behaviours. While in hospital, they were discharged from the long-term care home. The physician attending to the resident at that time, did not perform the discharge.

By discharging the resident from the long-term care home, the resident no longer had a permanent home or place to live.

Sources: Progress notes for the resident, Interview with the hospital and home's physician, and interview with ADOC.

[729]

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 of the requirements of O. Reg. 246/22, s. 161 (2) were met prior to discharging a resident from the long-term care home.

Summary and Rationale

A resident was sent to hospital due to an escalation of responsive behaviours. While in hospital, they were discharged from the long-term care home.

Neither the resident or their POA were notified of the home's plan or decision to discharge prior to them being discharged from the home. They were not notified in writing nor were they involved in making alternative arrangements for the care of the resident.

The home did not request the assistance of HCCSS, hospital or other community partners to work with the home to find alternative arrangements or accommodations for the resident when they exhibited responsive behaviours or expressed their wishes to leave the home.

The resident was at risk of not having a place to live when they were discharged from the Long-Term Care Home.

Sources: A residents progress notes, HCCSS referral, physician order form, email between Resident Family Experience Coordinator (RFEC) and HCCSS placement coordinator. Interview with the ADOC, RFEC, and Physicians.
[729]

COMPLIANCE ORDER CO #001 Residents' Bill of Rights

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. i.
Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of their plan of care,

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with [FLTCA, 2021, s. 155 (1) (b)]:

The licensee shall prepare, submit and implement a plan to ensure that staff are involving residents' in the development, implementation, review and revision of their plan of care.

The plan shall include but is not limited to:

1. How the home will ensure that residents who are capable, are encouraged to participate in the development, implementation, review, and revision of their plan of care.
2. Who will be responsible for ensuring that those residents who are capable and wish to participate are provided that opportunity.
3. How the home will document and validate in the plan of care for those residents who do not wish to participate or who do not have the capacity to be involved in the development of their plan of care.
4. How the home will balance the rights of the resident and the POA's wishes in relation to their participation in the development and implementation of the plan of care.

Please submit the written plan for achieving compliance for inspection #2024-1142-0002 to Kim Byberg (729), LTC Homes Inspector, MLTC, by email to centralwestdistrict.mltc@ontario.ca by June 7, 2024.

Please ensure that the submitted written plan does not contain any PI/PHI.

The licensee must be compliant with s. 3 (19)(i) of the FLTCA.

Specifically, the licensee must:

1. Educate all Physicians, Nurse Practitioners, ADOC, DOC, Resident Family Experience Coordinator and Executive Director regarding the criteria and process to be followed when discharging a resident from a long-term care home as per O. Reg 246/22 s. 161 (1) and O. Reg 246/22 s. 161 (2).
2. Document the education as outlined in part 1) including the date, format, staff attending the training, the person providing the education. The education records must be available and kept in the home.

Grounds

The Licensee failed to ensure that a resident's right to participate fully in the development, implementation, review, and revision of their plan of care was respected.

Summary and Rationale

A Resident's care plan, developed on the day of their admission, described their day as getting up at a specified time, being provided variation and flexibility in their routine, and participating in specific activities they had done prior to their admission.

During the resident's admission conference, the resident expressed that they wanted to engage in specific activities. The resident was told that it would be up to the nurse's assessment if it was safe for them to engage in the activities.

The resident occasionally declined their medication when it was offered and would get upset when staff re-approached them after they declined. This type of response also occurred when the resident requested to engage in specific activities that they did prior to being admitted to the home, but were prevented from doing them. Their plan of care was not adapted to include the resident's participation and preferences on how staff should manage their care when they refused, or when the home would not allow the resident to participate in specified activities.

The ADOC stated that they were aware that the resident did not want to live at the home, and when the residents' responsive behaviours escalated, the home decided it was not an appropriate place for the resident to live. The home did not consult with the resident in relation to their wishes or preferences for alternative accommodations. Instead, they discharged the resident while they were in the hospital, without providing any notice or opportunity to be involved in the decision.

The resident was not provided the opportunity to be involved in the decision-making processes that directly impacted them and their individualized plan of care. Not involving the resident, violated their right to participate fully in the development, implementation, and revision of their plan of care. The resident said this made them feel like they were in jail which escalated their responsive behaviours and later resulted in them being sent to the hospital. They were then discharged from the home without being informed, and without being part of the decision-making process.

Sources: A residents care plan, progress notes, assessments, and HCCSS referral. Interview with ADOC, RFEC, the resident, HCCSS placement coordinator and manager.

[729]

This order must be complied with by July 5, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE: The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care

438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice

must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.