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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 15, 2019	2019_640601_0001	033264-18	Complaint

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

Maplewood
12 Maplewood Avenue Box 249 BRIGHTON ON K0K 1H0

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

KARYN WOOD (601)

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): January 7, 8, 9 and 10, 2019.

Complaint log #033264-18 related to the requirements on licensee before discharging a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator and the Manager of the identified facility.

The Inspector conducted an off-site complaint inspection and reviewed the resident's health care records.

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

During the course of this inspection, Non-Compliances were issued.
- **1 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	Légende 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. 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 under subsection 145 (1) that the resident was kept informed and given an opportunity to participate in the discharge planning and that his or her wishes were taken into consideration.

O. Reg. 79/10, 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.

Related to log #033264-18:

The Ministry of Health Information Line received a complaint from the Manager of a facility that the resident was transferred to on an identified date. The Complainant reported that the Long-Term Care home (LTCH) had discharged resident #001 from the LTCH a number of days after the resident had been admitted to the identified facility. The Complainant also reported that resident #001 was deemed ready to return to the LTCH

and that the resident wanted to return to the home.

During a telephone interview on an identified date, Inspector #601 spoke with the Complainant. The Complainant indicated that resident #001 had been admitted to the facility on an identified date from the LTCH and was ready to be discharged back to the LTCH a number of days later. According to the Complainant, the Social Worker from the facility received a telephone call from the Administrator from the LTCH, on an identified date and was informed that resident #001 had been discharged from the LTCH. The complainant indicated that resident #001 does not meet the criteria to remain at the identified facility and the resident wants to return to the LTCH.

Inspector #601 reviewed resident #001's clinical health record, which indicated that the resident was able to make their own decisions and direct their own care.

During telephone interviews on two identified dates, the Administrator told Inspector #601 that resident #001 had been sent to the identified facility on an identified date, due to identified responsive behaviours. According to the Administrator, they received a call from the identified facility indicating that resident #001 would be returning to the LTCH after a number of days stay. The Administrator reported that the care team was concerned that resident #001 required a longer stay at the identified facility. At this time, a discussion was held with the Physician and it was determined that the LTCH could not provide a sufficiently secure environment, to ensure the safety of resident #001 or the safety of other residents. The Administrator said that the Local Health Integration Network (LHIN) and the identified facility were made aware of the decision to discharge the resident from the LTCH on an identified date. The Administrator also indicated that resident #001's discharge letter dated a number of days after the resident had been discharged from the LTCH, was mailed to the resident on the same day it was written. The Administrator also reported that they did not speak directly with resident #001 and does not know when this was communicated to the resident or when the resident received the discharge letter.

Inspector #601 reviewed the discharge letter addressed to resident #001, signed by the Administrator of the Long-Term Care Home (LTCH) and was written a number of days after the resident had been discharged from the LTCH. The discharge letter read, "Please accept this letter as written notice that we have formally discharged resident #001 from our care as of an identified date".

Inspector #601 reviewed resident #001's identified progress note completed by the

Registered Practical Nurse at the identified facility, dated a day after resident #001 had been discharged from the LTCH. The progress note read that resident #001 asked when they would be able to return to the nursing home.

The licensee did not ensure that resident #001 was kept informed and given an opportunity to participate in the discharge planning, while admitted to the identified facility and their wishes were not taken into consideration, when the LTCH sent resident #001 a discharged letter a number of days after being discharged from the LTCH, informing the resident that they had been discharged from the LTCH. [s. 148. (2)]

Issued on this 22nd day of January, 2019

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

Original report signed by the inspector.