Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 2, 4, 2013	2013_049143_0057	O-001100-13	Complaint

Licensee/Titulaire de permis

The Corporations of the United Counties of Leeds and Grenville, the City of Brockville, the Town of Gananoque and the Town of Prescott
c/o St. Lawrence Lodge, 1803 County Road 2, BROCKVILLE, ON, K6V-5T1

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

ST. LAWRENCE LODGE
1803 County Road, #2 East, Postal Bag #1130, BROCKVILLE, ON, K6V-5T1

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

PAUL MILLER (143)

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): November 19th-22nd, 2013

During the course of the inspection, the inspector(s) spoke with the resident, the Medical Advisor, the Administrator, the Director of Care, an Assistant Director of Care, the Director of Support Services, two Personal Support Workers, a Hospital Patient Flow Manager and a Planning and Integration Consultant with the South East Local Health Integration Network.

During the course of the inspection, the inspector(s) reviewed a resident health care record inclusive of assessments, physician orders, care plans, referrals, observed and noted the homes inventory of equipment.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Hospitalization and Death

Findings of Non-Compliance were found during this inspection.

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

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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

Findings/Faits saillants :

On a specified date Resident #1 was transferred to Hospital and admitted. On or about eight days following hospitalization an attending physician called St. Lawrence Lodge (SLL) to inform the home that Resident #1 was medically cleared to be transferred back to SLL. The hospitals attending physician was informed by nursing staff at the home that SLL would not accept the resident back. A hospital discharge planner spoke with the Director of Care (DOC) at SLL (nine days following admission to hospital) and was informed that the home could not accept resident #1 back to the home related to safety concerns. Ten days post hospital admission the Manager of Patient Flow at the hospital spoke with SLL Medical Advisor and was informed that the home could not accept Resident #1 back and expressed concerns related to staffing issues.

On day twenty-six, of resident #1's medical leave, SLL Medical Advisor wrote an order discharging Resident #1 from the home. On or about four days (post physician discharge order) Resident #1 (while hospitalized) received a letter from the Director of Care at SLL indicating that the home could not provide a sufficiently secure environment to ensure her/his ongoing safety.
On a specified date during a telephone interview with Resident #1, she/he reported that the home had not advised her/him of their discharge plan, prior to her/him receiving the letter. Resident #1 reported that it was her/his desire to return to her/his home at SLL.
On November 20th, 2013 the Director of Care reported to the inspector that she or no other staff at the home had advised Resident #1 that she/he was discharged, prior to receiving the letter of discharge. The Director of Care confirmed with the inspector that upon reviewing Resident #1's health care record that the home had no documentation to indicate that Resident #1 had been advised of the home's plan to discharge.
On November 22, 2013 during a telephone interview the Medical Advisor confirmed with the inspector that he had not informed or discussed with Resident #1 his/her plan to discharge her/him prior to writing the order.
On November 26th, 2013 at 1400 hours the inspector conducted a telephone interview with the Administrator and the Director of Care. These individuals were asked why Resident #1 was not given notice prior to discharge and if there were any circumstances preventing them from giving her/him notice of discharge. The Administrator advised the inspector that he did not know the process nor was aware of the procedure needed to complete the discharge. The Director of Care indicated that she had reviewed the requirements for discharging a resident in 2010 when the new

Act and Regulations came in effect but had not reviewed them prior to giving Resident #1 the discharge letter. The Director of Care indicated that this is the home's first experience with discharging a resident under these circumstances. The Administrator and the Director of Care indicated that they believed the authority to discharge a resident came when an attending physician wrote an order to discharge. A general discussion occurred in respect of St. Lawrence Lodge Home for the Aged discharge-resident procedure (#0401-05-34) review date August 2005.

Pursuant to regulation O.Reg 79/10 section 148.(2)
(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;
(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 his or her 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. O. Reg. 79/10, s. 148 (2).

On a specified date during a telephone interview, Resident #1 was questioned about the number of staff required to transfer her/him and indicated that 2 staff are required to assist with transfers.
Two Personal Support Workers were interviewed on November 19th (S102 and S103) and both confirmed that the resident required 2 staff to assist with transfers and that three staff may be required as needed.
On November 22, 2013 during a telephone interview the Medical Advisor informed the inspector that he had discharged Resident #1 based on the fact that the home did not have sufficient resources to manage her/him. The Medical Advisor reported that other residents were at risk while staff provided Resident #1 with care. The Medical Advisor indicated that he would not assume the risk and that Resident #1 was better managed

in complex care.

A review of Resident #1 health care record indicated that on a specified date in 2012 the home's Social Worker (SW) completed a consult to the Medical Advisor requesting that Resident #1 be referred to a hospital outpatient program.
On November 22, 2013 the Medical Advisor could not confirm with the inspector that this referral had been completed.

On November 19th, the DOC provided the inspector with an email dated July 15, 2013 to the South East Community Care Access Centre. This email indicated that the home was having issues with meeting Resident #1's needs and questioning what alternative accommodations may be available to her/him. On July 25th, 2013 the DOC received a response indicating that the issue had been forwarded to the Local Health Integration Network (LHIN). On November 21st, 2013 the LHIN forwarded information to the inspector indicating that a voice mail message was left with the home advising them that additional staff resources could not be provided under the current funding. The Inspector was informed by staff with the LHIN that the home had not consulted with them any further in respect of Resident #1.

On a specified date Resident #1 was referred to a community agency. On November 20th, 2013 (approximately two and one half months following this referral) the DOC indicated that Resident #1 had not been assessed and that the home had not followed up with the referral.

The DOC reported to the inspector that alternatives to discharge had not been considered in respect of the hospital outpatient program and the community agency and that these referrals had not been followed up. The DOC reported to the inspector that these alternatives for treatment were not tried prior to discharge. The DOC confirmed discussions with a placement co-ordinator however alternative accommodations for the care of the resident had not been made. The DOC informed the inspector that the resident, who is capable to make her/his own decisions had not been involved in the discharge planning nor her/his wishes taken into consideration prior to discharge letter.

On November 26, 2013 the inspector received an update from Resident #1's hospital indicating that Resident #1 continues to be medically stable. Resident #1 continues to require two staff to assist with transfers and it is her/his desire to return to their home

at SLL.

It should be noted that Ontario Regulation 79/10 section 148.(3) was not issued as part of these findings. [s. 148.]

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. On a specified date Resident #1 was admitted to Hospital. On a specified date Resident #1 was discharged from her/his home at St. Lawrence Lodge (SLL), while on a medical leave. On or about four days following SLL discharging her/him, Resident #1 received a letter informing her/him that she/he had been discharged. On a specified date resident #1 reported to the inspector (during a telephone discussion) that prior to receiving the letter she/he had not been informed of the homes plan to discharge her/him. Resident #1 reports that she/he wishes to return to SLL.
The licensee has failed to comply with Ontario Long-Term Care Homes Act 2007, section 3.(1) 9. by not ensuring their right, to participate in decisions, related to discharge. [s. 3. (1) 9.]

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 residents right to participant in decision making be respected, to be implemented voluntarily.

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THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 148.	CO #901	2013_049143_0057	143

Issued on this 4th day of December, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
JMcFarland for Paul Miller