Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Aug 6, 2020	2020_594746_0009	014851-20	Complaint

Licensee/Titulaire de permis

St. Joseph's at Fleming
659 Brealey Drive PETERBOROUGH ON K9K 2R8

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

St. Joseph's at Fleming
659 Brealey Drive PETERBOROUGH ON K9K 2R8

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

AMANDEEP BHELA (746)

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): July 30, 31, August 4 and 5, 2020 as an off-site inspection.

One Log related to admission and discharge.

During the course of the inspection, the inspector(s) spoke with Manager of Strategy, Development and Special Projects, Acting Director of Care (A-DOC) and Administrator.

During the course of the inspection, the inspector reviewed health 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 failed to ensure that before discharging a resident, the licensee shall, 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 the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

The Ministry of Long-Term Care (MLTC) received a complaint on an identified date, indicating that the home was not going to re-admit resident #001 from hospital as they were on an identified medical device. The MLTC received a second complaint from the complainant on an identified date indicating that resident #001 was discharged from the home while in hospital and was not provided written notice before being discharged from the home.

A review of resident #001's electronic clinical records indicated the following:

- On an identified date, resident #001 was experiencing a change in status and was transferred and admitted to hospital.

- On an identified date, it was noted that a meeting was held with the care team from the hospital, where concerns and risks around resident #001's care needs and the need for the identified medical device were discussed. The note further indicated, that the home would not be able to support the medical device at the facility and a follow-up teleconference would be scheduled.

- On an identified date, a teleconference was held to discuss readmission of resident #001 back to the home. The note indicated that resident #001 was no longer on the identified medical device and was now using a different medical device. The note indicated that after the teleconference ended, further discussion was held with the Director of Care (DOC) and that due to identified properties of the medical devices, resident #001 would not be able to be re-admitted from the hospital to the home.

- On an identified date, it was noted that the resident had exceeded 30 days post outbreak and resident #001 was no longer eligible for Long Term Care (LTC) bed. The note further indicated that resident #001 remained in hospital, on the medical device and has been non-compliant with specific LTC rules, home had been in communication with the hospital and had declared that the resident had been discharged from the home.

A review of the dated discharge letter addressed to resident #001 indicated that resident #001 was not eligible for re-admission as the home lacks the physical facilities necessary to meet the applicant's care requirements. The discharge letter also indicated that resident #001 had historical, consistent non-compliance with identified policies and pandemic measures. There were concerns with shared accommodation, where home could not isolate upon admission while using the identified medical device.

In an interview Manager #101, indicated that meetings were held between the home and the hospital to discuss resident #001's readmission back to the home, upon review of resident care needs with the DOC it was determined that resident #001 would not be able to be re-admitted to the home as the resident was on an identified medical device. Manager #101 indicated it was there understanding that the social worker at the hospital would inform the resident of this decision. Manager #101 further shared a letter which was sent to resident #001 on an identified date outlining the reasons why the home would not be re-admitting the resident.

In an interview Acting Director of Care (A-DOC), confirmed that resident #001 was officially discharged from the home's system on an identified date and that the home

provided the discharge letter to resident #001 on an identified date which was after the resident was discharged from the home.

The licensee failed to ensure that before discharging resident #001 on the identified date, a written notice was provided to the resident, the resident's substitute decision-maker, if any, and any person, setting out a detailed explanation of the supporting facts, as they relate to the home, resident's condition and requirements for care that justify the licensee's decision to discharge the resident. A written notice was provided to the resident on an identified date, after the resident was discharged. [s. 148. (2)]

Issued on this 7th day of August, 2020

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

Original report signed by the inspector.