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 # / No de registre	Type of Inspection / Genre d'inspection
Jul 20, 2017	2017_605213_0013	012883-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

McGARRELL PLACE
355 McGarrell Drive LONDON ON N6G 0B1

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

RHONDA KUKOLY (213), NANCY SINCLAIR (537), TRACY RICHARDSON (680)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): July 4, 5, 6, 7, 11, 12, 2017

During this Resident Quality Inspection, the following concurrent inspections were completed:
Log #035475-16, Critical Incident #2964-000046-16 related to falls.
Log #022118-16, Critical Incident #2964-000021-16 related to falls.
Log #025104-16, Critical Incident #2964-000026-16 related to falls.
Log #005001-17, Critical Incident #2964-000016-17 related to falls.
Log #009298-17, Critical Incident #2964-000026-17 related to falls.

Log #029274-16, Critical Incident #2964-000032-16 related to medications.
Log #009283-17, Critical Incident #2964-000025-17 related to an injury resulting in a transfer to hospital and change in condition.
Log #004963-17, Critical Incident #2964-000014-17 related to resident to resident abuse.
Log #027285-16, Critical Incident #2964-000028-16 related to resident to resident abuse.
Log #011560-17, Critical Incident #2964-000031-17 related to resident to resident abuse.
Log #011154-17, Critical Incident #2964-000030-17 related to resident to resident abuse.
Log #005828-17, Critical Incident #2964-000020-16 related to resident to resident abuse.
Log #031108-16, Critical Incident #2964-000040-16 related to resident to resident abuse.
Log #008736-17, Critical Incident #2964-000024-17 related to resident to resident abuse.
Log #003652-17, Critical Incident #2964-000009-17 related to resident to resident abuse.
Log #029605-16, Critical Incident #2964-000033-16 related to resident to resident abuse.
Log #007190-17, Infoline #IL-50233-LO, a complaint related to resident to resident abuse.
Log #033277-16, Critical Incident #2964-000042-16 related to alleged staff to resident abuse.
Log #021822-16, Critical Incident #2964-000020-16 related to alleged staff to resident abuse.
Log #020848-16, Infoline #IL-45627-LO, a complaint related to alleged staff to resident abuse/neglect.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Associate Director of Care, the Quality Manager, the Resident Services Coordinator, the Director of Recreation, the Educator, the Resident Assessment Instrument (RAI) Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, residents and family members.

The Inspectors also conducted a tour of all resident areas and common areas, observed residents and care provided to them, medication passes, medication

storage areas, reviewed health care records and plans of care for identified residents, policies and procedures, training records, minutes from meetings and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **7 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

a) A Critical Incident System (CIS) report submitted to the Ministry of Health and Long-Term Care by the home indicated that on an identified date, a resident fell resulting in an injury. Since this incident, the resident has had a number of falls.

Review of three post fall assessments, documented that resident used an identified intervention related to falls.

The resident was observed with the intervention in place and a staff member stated that the resident was to use this intervention. The staff member stated that the kardex on Point of Care (POC) would have the information for the interventions required for the resident.

The kardex was reviewed on POC by staff member and the Inspector, and there was no documentation to indicate the use of the intervention. The kardex and care plan was also reviewed by a registered staff who also was unable to locate documentation to support the use of the intervention.

In an interview, the Director of Care stated that the plan of care for this resident did not provide clear direction to staff and others who provided direct care to the resident regarding the intervention.

b) A Critical Incident System (CIS) report submitted to the Ministry of Health and Long-Term Care by the home indicated that on an identified date, a resident sustained a fall that resulted in a an injury. The resident has had subsequent falls since this incident.

An observation of the resident room showed an intervention in use. A staff member stated that the intervention in the observed position would be for a specific purpose. The staff member stated that they were unsure what the care plan stated for this intervention. The staff member and the Inspector reviewed the care plan for the resident. The care plan included two separate different interventions that were different than the observed intervention.The last Minimum Data Set (MDS) assessment showed the use of the intervention.

A registered staff member reviewed the care plan and stated that the direction to staff was not clear, and that it would need to be determined what was actually required.

The Director of Care stated that the care plan should provide clear direction to staff and others who provided care to the resident regarding the use of the identified intervention.

The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to two residents regarding identified interventions. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A review of electronic documentation was completed for a resident, including Minimum Data Set (MDS) assessments, the care plan, and Point of Care (POC) documentation in Point Click Care (PCC). The MDS assessment, dated completed in one identified month, stated a level of assistance. The MDS assessment dated completed three months later stated an increased level of assistance was required for a particular activity of daily living (ADL). The POC documentation for the most recent 30 day period of time in PCC showed that the resident required an increased level of assistance with the particular ADL on 20 of the 30 days.

In an interview with a registered staff member, the staff member said that the POC documentation in PCC showed that the resident required an increased level of assistance with a particular activity of daily living. After reviewing the plan of care for the resident with the Inspector, the registered staff said that as the care plan indicated the resident required a lesser level of assistance, therefore the care plan did not reflect the resident's current needs related to the particular activity of daily living.

The licensee failed to review and revise the plan of care for resident when the resident's care needs changed.

The severity of this non-compliance is potential for harm and the scope is isolated. The home does have a history of non-compliance in this subsection of the legislation, s. 6 (10)(b) was issued as a Voluntary Plan of Correction in the Resident Quality Inspection in February 2015. [s. 6. (10) (b)]

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 the plan of care set out clear directions to staff and other who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone of a resident by the licensee or staff that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

a) During an interview by the Inspector with a resident, the resident stated that in the morning that day, they experienced verbal abuse by a staff member, and was upset over the incident. The inspector shared this information with the Director of Care (DOC) for follow up.

On review of the Client Services Response Form (CSR) (the home's complaint documentation forms), it showed that the DOC had met with the resident. The documentation showed that the resident had stated they experienced verbal abuse and that the resident felt afraid. The CSR showed that the investigation with staff started the following day.

The Ministry of Health and Long-Term Care (MOHLTC) Critical Incident Reporting System (CIS), showed that a CIS report had been submitted to the MOHLTC by the home the day after the incident was reported related to alleged staff to resident abuse. In the CIS, it was noted that the police had been notified of the incident.

The DOC stated that during the initial investigation meeting, the resident had stated that they were afraid of verbal abuse by staff. The DOC also stated that the resident had never made an allegation towards staff before this and that the staff member had never been reported for alleged abuse previously.

The DOC acknowledged the alleged verbal abuse was not immediately reported to the Director. The DOC stated that they had followed the MOHLTC decision trees for licensee reporting of verbal abuse. The DOC said it was an allegation, and that an investigation was done immediately and was not pointing towards verbal abuse.

The Executive Director stated that the practice of the home is for the managers to do an immediate investigation and follow the MOHLTC decision trees for reporting, if they have reasonable grounds or if they are not 100 per cent certain that it did not happen they would then report to the Director. The Administrator stated that after consultation with the Regional Director, a CIS report was submitted to the Director related to the allegation of verbal abuse.

The home was notified that resident had alleged they had experienced verbal abuse by a staff. The investigation was initiated that day, completed the following day, and a critical incident was submitted to the Director after the investigation was completed. The licensee failed to immediately report an allegation of verbal abuse of a resident to the Director.

b) Review of the home's complaint log showed a CSR, stating the home had a complaint that a resident had witnessed another resident inappropriately touching another resident.

The CSR showed the investigation was done the day of and the day after the incident was reported and in the comments section it stated that residents were being monitored and that the home was taking appropriate steps. Completion of the form was signed the day after it was reported.

The home's internal investigation records were reviewed and showed that a registered staff member had stated that a resident was touching the resident but was not sure if it was inappropriate.

Progress notes by a registered staff member, stated that a resident was touching another resident, staff were unsure of what the resident was doing, and documented that a third

resident had seen the resident very close to another resident. The registered staff also documented direction for staff to observe other residents getting close to the resident as this resident was unable to speak for themselves. A progress note written by a registered staff member stated that the third resident had complained that an identified resident was behaving inappropriately with another resident and that staff intervened and separated them from each other. The note also stated that an investigation was done.

In an interview with a staff member by the Inspector, the staff stated that they had been in the servery at the time of the incident and that the residents could be visualized from that location. The staff member stated that one resident was seen touching another resident but that they could not say if it was sexual in nature or not and had told management the same thing. The staff member stated that the resident was easily redirected at that point.

The DOC stated that the incident was not reported to the Director as they did not feel there was any sexual behaviour by one resident towards another resident as they felt it was not true. The DOC stated that they do not believe an allegation is true or not true until an investigation is completed.

In an interview with the ED, they stated that the expectation was that the investigation would begin immediately and that they would report that day to the Director. The ED said if the investigation was not completed that day, or if they had any doubt about the incident, a CIS would be submitted.

An alleged sexual abuse of a resident, reported to staff by another resident, was reported from a registered staff to a manager on an identified date. The investigation was signed as completed the following day by the DOC. In an interview with a staff member, they were unable to say if the incident that they witnessed was sexual or not. The incident was not reported to the Director.

c) Another CSR stated that a resident's spouse had notified a registered staff member of an allegation of physical abuse of the resident. Documentation on the CSR showed that the staff were contacted and a head to toe assessment was completed. It also stated that there was no injury noted. Staff were interviewed and the comments noted that there was no staff to resident physical abuse.

Progress notes showed that a resident's spouse had notified a registered staff member of an allegation of physical abuse and wanted to know who had provided care to the

resident on a particular date. Registered staff documented that the charge nurse was notified of the incident and an investigation needed to be completed.

The MOHLTC CIS was reviewed and no report was found related to an incident of alleged physical abuse related to the resident. In an interview, the DOC acknowledged that no CIS had been completed for this complaint of physical abuse.

Registered staff were notified of an alleged physical abuse, and reported the incident to management the next day and an investigation was initiated. It was not reported to the Director.

The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone occurred, immediately reported the suspicion and the information upon which it was based to the Director.

The severity of this non-compliance is minimum risk and the scope is isolated. The home does have a history of non-compliance in this subsection of the legislation, it was issued as a Voluntary Plan of Correction in May 2016 and as a Voluntary Plan of Correction in February 2015. [s. 24. (1)]

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 any person who has reasonable grounds to suspect that abuse of a resident by anyone of a resident by the licensee or staff that resulted in harm or risk of harm, immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

The Critical Incident System (CIS) is the means in which homes report to the Director.

a) A CIS report was submitted to the Ministry of Health and Long-Term Care by the home, regarding alleged staff to resident abuse.

On review of the CIS, it showed that an update had not been provided regarding the results of the investigation. The home was not able to provide investigation notes for review.

In an interview with the Director of Care (DOC), the DOC stated that an update had not been completed related to the CIS, and that the notes of the investigation could not be found regarding this incident.

In an interview with the Executive Director (ED), the ED stated that the expectation was that the CIS report was updated within 21 days and agreed that this was not done related to the identified CIS related to alleged staff to resident abuse.

b) Another CIS report was submitted to the Ministry of Health and Long-Term Care by the home regarding alleged staff to resident abuse.

On review of the CIS, it showed that an update had not been provided regarding the results of the investigation. The amendment to the report submitted, stated the investigation was complete. The results of the investigation were not submitted with that amendment.

In an interview with Director of Care (DOC), the DOC stated that an update had not been reported on the CIS. The DOC stated that they were not aware of what needed to be

updated and acknowledged an update on the complete investigation had not been provided.

In an interview with the Executive Director (ED), the ED stated that the expectation was that the CIS report was updated within 21 days and agreed that this was not done related to the CIS related to alleged staff to resident abuse.

The licensee failed to ensure that two CIS reports were updated with the results of the investigations of alleged staff to resident abuse and therefore, the results of the alleged abuse investigation were not reported to the Director.

The severity of this non-compliance is minimum risk and the scope is isolated. The home does not have a history of non-compliance in this subsection of the legislation. [s. 23. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

The home reported a Critical Incident System (CIS) report to the Ministry of Health and Long Term Care regarding resident to resident abuse where an altercation between two residents causing a fall and injury to one of the residents.

The health records, both paper and electronic in Point Click Care (PCC) for both residents were reviewed. There was a progress note related to the incident; however, there was no post fall assessment completed in PCC related to the fall.

The Quality Manager was interviewed, and they said that the expectation in the home was that post falls assessments were completed in PCC under the Assessments tab, there was a specific assessment tool in PCC to complete post fall assessments. The Inspector and the Quality Manager also reviewed the electronic records for the resident and the Quality Manager said that there was no post fall assessment completed related to the fall identified in the CIS report.

The licensee failed to ensure that when a resident fell, a post-fall assessment was conducted using a clinically appropriate assessment instrument specifically designed for falls.

The severity of this non-compliance is minimum risk and the scope is isolated. The home does not have a history of non-compliance in this subsection of the legislation. [s. 49. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

The home reported a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care regarding an incident of resident to resident abuse where an altercation between two residents occurred causing an injury to one of the residents.

The health records, both paper and electronic in Point Click Care (PCC) for both residents were reviewed. There was a progress note related to the incident noting the injury of altered skin integrity; however, there was no skin assessment completed in PCC or in the resident's paper chart related to the injury.

The Quality Manager was interviewed and said that the expectation in the home was that and skin assessments were completed on paper at the time of the incident. The Inspector and the Quality Manager also reviewed the electronic records for the resident and the Quality Manager said that there were no assessments completed in PCC related to the injury.

A registered staff member was interviewed, and after reviewing the paper chart for the resident, the staff said that there was no skin assessment for the resident for the injury that occurred. The staff member said that skin assessments were to be completed in paper form.

The licensee failed to ensure that when a resident suffered an injury of altered skin integrity, a skin assessment was conducted by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

The severity of this non-compliance is minimum risk and the scope is isolated. The home does not have a history of non-compliance in this subsection of the legislation. [s. 50. (2) (b) (i)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Medication incident reports were reviewed for an identified quarter, and there were 13 medication incident forms. The Director of Care (DOC) also provided a spread sheet for review that had the medication incidents listed.

Three incidents were chosen for further review. Two of the incidents were from the quarter, and the third was a Critical Incident System (CIS) report that was submitted by the home regarding a medication incident of a missing or unaccounted for controlled substance.

a) The Medisystem Pharmacy policy titled "Medication Incident Reporting" last reviewed January 16, 2017, stated: "Notify pharmacy immediately that a medication incident has occurred in order to correct the error as soon as possible".

The medication incident report for one resident stated that the pharmacy had not been notified of the medication incident, and stated under comments: "nursing issue". The

Director of Care (DOC) stated that the pharmacy had not been notified as the incident was determined to be a nursing related error, and therefore, pharmacy had not been notified of the incident. The DOC stated that it was expected that the pharmacy be notified of all medication incidents.

b) The Medisystem Pharmacy policy titled "Medication Incidents" last reviewed January 17, 2017, stated: The error or adverse drug reaction is also to be reported to the resident and/or substitute decision maker".

The medication incident report for another resident did not indicate that the Family/Power of Attorney (POA) had been notified of the medication incident. Review of the Point Click Care (PCC) clinical record stated a request for the POA of the resident to be notified following the recognition of the medication incident and initiation of the incident report. There was no documentation in PCC to support that the POA had been notified. The Director of Care (DOC) stated that the home had a communication book where it would have been recorded to notify the POA on the following shift. The communication book did include documentation to support the request to notify the POA but did not support that the notification had occurred. The DOC stated that it was expected that the POA be notified of a medication incident involving a resident.

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's SDM and the pharmacy service provider.

The severity of this non-compliance is minimum risk and the scope is isolated. The home does not have a history of non-compliance in this subsection of the legislation. [s. 135. (1)]

WN #7: 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).

Findings/Faits saillants :

1. The licensee has 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.

Record review of progress notes for resident was completed and it was noted that the resident was discharged from the home as of an identified date. There were no notes related to the discussion of discharge from the home with the resident or substitute decision maker (SDM).

In staff interviews with the Director of Care and Associate Director of Care, they both said that the resident was discharged from the home on an identified date and that the substitute decision maker was notified after the discharge had occurred.

The licensee has failed to ensure that before a resident was discharged, notice of the discharge was given to the resident, the resident's substitute decision-maker as far in advance of the discharge as possible.

The severity of this non-compliance is minimum risk and the scope is isolated. The home does not have a history of non-compliance in this subsection of the legislation. [s. 148. (1) (a)]

Issued on this 17th day of August, 2017

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

Original report signed by the inspector.