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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 13, 2015	2015_271532_0028	013399-15	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

FOREST HEIGHTS
60 WESTHEIGHTS DRIVE KITCHENER ON N2N 2A8

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

NUZHAT UDDIN (532)

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): October 7, 8, 9, 2015.

This was a complaint inspection related to discharge.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Environmental Service Manager, Associate Director(s) of Care, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping staff, residents and family member.

The inspector also toured the resident home areas, reviewed clinical records, observed the provision of care and interaction between staff and residents, reviewed relevant policies and procedures, reviewed educational records, general maintenance of the home, as well as meeting minutes pertaining to the inspection.

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)**
- **1 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 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) there was a) alternatives to discharge were considered and where appropriate tried; b) collaboration with the appropriate placement co-ordinator and other health service organizations, alternative arrangements for the accommodation, care and secure environment required by the resident.

A written complaint addressed to the Executive Director (ED) was received. The complaint was concerning an identified Resident who was discharged from the home and the home did not follow the appropriate legislative requirements.

Record review stated that the identified resident had responsive behaviours.

Record review revealed that there were reported incidents of altercation.

After an incident the home sent a letter to the Power of Attorney (POA) stating that the resident was discharged from the home.

The Community Care Access Center Case Manager (CCAC) was contacted by Inspector #532 and the Case Manager confirmed that the home did not follow the discharge protocol for the identified resident.

Another Community Care Access Centre Case Manager contacted by Inspector #532, reported that the resident was awaiting to be placed in a Long Term Care (LTC) bed and there were no responsive behaviours at this time.

The ED confirmed that the home did not have a discharge policy.

Record review indicated that the POA was contacted on a specified date before the incident and a suggestion was made to start an application process for placement the identified resident and the POA was in agreement to contact the CCAC. However, the identified resident was discharged from the home before the process was initiated.

The licensee failed to ensure that when they discharged the identified resident that alternatives to discharge were considered and alternative arrangements for the accommodation, care and secure environment required by the resident was considered in collaboration with the appropriate placement co-ordinator and other health service organizations.

This is further evidence to support the Compliance Order issued on August 20, 2015. [s. 148. (2)]

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 before discharging a resident under subsection 145 (1) (the resident's requirements for care have changed and as a result, the home cannot provide a sufficiently secure environment to ensure the safety of the resident of the safety of persons who come into contact with the resident), the licensee,
(a) ensure that alternatives to discharge were considered and, where appropriate, tried;
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, made 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 are 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, to be implemented voluntarily.

Issued on this 16th day of November, 2015

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

Original report signed by the inspector.