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

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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
Jan 7, 2016	2015_347197_0035	O-002550-15	Complaint

Licensee/Titulaire de permis

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

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

KENTWOOD PARK
2 ONTARIO STREET PICTON ON K0K 2T0

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

JESSICA PATTISON (197)

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 13-16 (on-site), October 19, 20, 2015 and January 6, 2016 (off-site)

This complaint inspection was started while on-site for the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, a Registered Nurse, the Omni Operations Manager - Clinical, a resident and the resident's POA.

The Inspector also reviewed a resident's health care record and an internal investigation file.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Continence Care and Bowel Management
Reporting and Complaints
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **2 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. 80. Regulated documents for resident

Specifically failed to comply with the following:

s. 80. (1) Every licensee of a long-term care home shall ensure that no regulated document is presented for signature to a resident or prospective resident, a substitute decision-maker of a resident or prospective resident or a family member of a resident or prospective resident, unless,
(a) the regulated document complies with all the requirements of the regulations; and 2007, c. 8, s. 80. (1).
(b) the compliance has been certified by a lawyer. 2007, c. 8, s. 80. (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 80(1) in that Resident #001 and the resident's family member were presented with a regulated document for signature that did not comply with all of the requirements of the regulations.

Resident #001 re-entered the home on a specified date after being sent to the hospital for assessment. Upon re-entry to the home, the POA of Resident #001 was presented with a document titled "Management of Serious or Worsening of Condition" for signature. At a minimum, this document included a directive with respect to "treatment" as defined in the Health Care Consent Act, 1996. On its face it claims to be an advance directive that contains the resident's wishes regarding medical care. It contains four levels of care and the signatory must choose a level of care that will be provided to the attending physicians and nurses as a guideline when critical decisions need to be made.

O. Reg. 79/10, s. 227(6) states that a document containing a consent or directive with respect to "treatment" as defined in the Health Care Consent Act, 1996, including a document containing a consent or directive with respect to a "course of treatment" or a "plan of treatment" under that Act,
(a) must meet the requirements of that Act, including the requirement for informed consent to treatment under that Act;
(d) must set out the text of section 83 of the Act.

The Management of Serious or Worsening of Condition document does not comply with the Health Care Consent Act, 1996 (HCCA). The document purports to capture the wishes of the resident expressed while the resident was capable as to what type of treatment the resident would want in an emergency. If that was its sole purpose, it might comply with the HCCA, which contemplates that the health practitioner would consider these wishes in the event of an emergency where the health practitioner cannot obtain consent from the resident, or the resident's substitute decision-maker before administering a treatment. The HCCA sets out rules for health practitioners in emergencies. This document, however, contemplates that a substitute decision-maker could choose a level of care on behalf of an incapable resident. A substitute decision-maker under the HCCA can only provide the known wishes of the resident expressed while the resident was capable to be taken into account in the event of an emergency. The document also conflates consent, or "decision-making" as it is described in the document, with wishes. The form goes beyond the capturing of a resident's wishes expressed while capable. In multiple places the form refers to the making of decisions.

This document is not a plan of treatment or a course of treatment within the meaning of the HCCA. If the document is also supposed to be a means of obtaining consent to treatment then there are multiple violations with the HCCA; in particular, a lack of information for the substitute decision-maker to provide informed consent to treatment.

LTCHA 2007, s. 83 (1) states every licensee of a long-term care home shall ensure that no person is told or led to believe that a prospective resident will be refused admission or that a resident will be discharged from the home because,
(a) a document has not been signed;
(b) an agreement has been voided; or,
(c) a consent or directive with respect to treatment or care has been given, not given, withdrawn or revoked.

The Management of Serious or Worsening of Condition document that was presented to Resident #001's husband for signature on July 17, 2015 did not contain the text of LTCHA 2007, s. 83 (1), as outlined above.

The Administrator confirmed via email on January 6, 2016, that the home did not have a lawyer certify that this document was in compliance with all of the requirements of the regulations. [s. 80. (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 no regulated document is presented for signature unless the regulated document complies with all of the requirements of the regulations, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 83. Coercion prohibited

Specifically failed to comply with the following:

s. 83. (1) Every licensee of a long-term care home shall ensure that no person is told or led to believe that a prospective resident will be refused admission or that a resident will be discharged from the home because,
(a) a document has not been signed; 2007, c. 8, s. 83. (1).
(b) an agreement has been voided; or 2007, c. 8, s. 83. (1).
(c) a consent or directive with respect to treatment or care has been given, not given, withdrawn or revoked. 2007, c. 8, s. 83. (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA s. 83 (1)(c) in that the Power of Attorney for Care of Resident #001 was made to feel as if the resident would not be re-admitted to the home from hospital unless the resident's level of care was changed to a level 1 - comfort measures only.

On a specified date, Resident #001 was sent to hospital for assessment. RN #100 wrote in the progress notes that that hospital called the home to inform them they were sending Resident #001 back. The note states that "writer has discussed resident's level of care and all have agreed to change level of care to level one - comfort measures only. Order received from Dr. Burke for nurse to pronounce and comfort measures level one - advanced directive".

Inspector spoke with the POA for Resident #001 who stated that on this specified date, RN #100 called and indicated that Resident #001 was being sent back from hospital and to come in. The resident's POA indicated that upon arrival RN #100 was standing there with a DNR (Do Not Resuscitate) form to sign. The POA states he/she didn't want to sign but that the RN stated she didn't care and to sign it or she would not allow the resident back into the home. The POA states he/she then signed the form but wrote "under duress". RN #100 was stated to then take the form and said to sign a new one without writing "under duress" or the resident could not come back. The POA then signed the form because he/she stated they knew the resident could not go home and the hospital would not take admit the resident. The POA states the next morning the home apologized and allowed he/she and Resident #001 to sign the form how they wanted to, as a level 4 - Transfer to Acute Care Hospital with Cardiopulmonary Resuscitation (CPR), which the resident was prior to signing the level 1. The POA stated that RN #100 still works in the home and that Resident #001 is scared that this RN will

not perform CPR if required.

Resident #001 was interviewed and indicated being a bit concerned that RN #100 would not provide the care required.

Resident #001's POA complained to the home and to the Omni head office that he/she felt they were forced to make Resident #001 a DNR and as a result, an investigation into the incident occurred.

The investigation by the home and Omni found the following:

- The POA for Resident #001 signed the Management of Serious or Worsening of Condition form on the specified date as a level 1 - comfort measures only, but underneath wrote "signed under duress". The POA then signed a second form, but did not date it and it was also indicated as a level 1. RN #100 and RN #101 also signed it and RN #101 dated it.

- A series of text messages were sent back and forth between the DOC and RN #100 on the specified date. In those text messages the RN indicated that the POA said they would not change the resident's level of care and that her response was that the level had to be 1 and that she would not discuss the matter any further.

- Progress note written by RN #100 stated POA for Resident #001 arrived prior to Resident #001's return. It further stated that the POA said he/she was being forced to sign a DNR form. The RN wrote that she explained that the POA did not have to sign the DNR, however, with resident's best interest and dignity considered, choosing a level 1 was advised.

- Progress note written by RN #101 stated POA for Resident #001 arrived and indicated being there to sign the papers, referring to the advance directive. RN #100 and #101 were said to go over the levels of care with the POA numerous times, as he/she felt that the resident would not be taken care of if not a level 4. RN indicates she explained to the POA that the only difference was that no CPR would be provided. All other treatment avenues could be utilized if required. POA was also informed that an order was received from the Physician for the resident to be DNR. POA agreed to sign the advance directive as level 1 and writer asked if he/she felt comfortable signing it and they indicated being ok with it.

Inspector made six attempts on various dates to contact RN #101 but was unsuccessful.

- Witness statement by RN #101 stated that she was told by RN #100 that Resident #001 was sent to hospital. She indicated she was told that Resident #001 was not to come back to the home unless the POA came to sign advance directive as level 1. RN #100 indicated she was told this by the DOC. POA arrived at 2320 hours and RN #101 spoke with him/her regarding level of care and that she was told that it had been discussed earlier and that he/she was to sign directive as level 1 and that they were in agreement with this. The POA then rescinded this decision. RN #101 spoke with the POA at length, with other RN, regarding CPR and levels of care and informed them that the only difference between the levels of care was CPR or no CPR. The POA was also informed that the directive could be changed. POA then stated to RN #101 that he/she felt they had to sign the document as level 1 or the resident would have nowhere to go. The POA signed the form "under duress". RN #101 called DOC to inform of situation and was told if the POA didn't want to sign directive and Resident #001 came back to the home, to send the resident back to hospital if necessary. The POA was informed of this and RN #101 said she would send resident back to hospital if she did not feel comfortable and confident of their status being at the home as level 4. At this time, the witness statement indicates that RN #100 rejoined the conversation and had the POA sign the directive as level 1, as she had been speaking to the Physician and DOC. The POA gave RN #101 the paperwork from the hospital and left.

In an interview on October 16, 2015, the DOC stated to the Inspector that she felt RN #100 took her text literally and that it was a serious miscommunication. When asked if she felt Resident #001's POA was made to feel that the resident could not return without signing the DNR, she said yes and that she was surprised RN #100 was so assertive with the POA.

During a phone interview on October 20, 2015 with the Omni Operations Manager - Clinical, who conducted the investigation, she stated that RN #100 was very remorseful and realized she swayed Resident #001's POA in one direction. She stated it was the decision of the Resident and the POA, but she felt that RN #100 did not support that decision at the time. RN #100 admitted to having a difficult time communicating with Resident #001's POA so that he/she understood the different levels of care. She felt that RN #100 really wanted to persuade the POA and kept saying that she wanted the POA to realize that CPR would hurt the resident. She stated that after the investigation she concluded that signing the level 1 was not what the POA wanted and that they felt

pressured to sign the document. She indicated that RN #100 should have just stopped and accepted the POA's decision.

RN #100 was interviewed by phone on October 19, 2015. She stated that the DOC told her not to let Resident #001 come back until the level of care changed. She indicated that the Physician said Resident #001 is a level 1 regardless and to write the order. RN #100 stated that she tried to explain the differences in the levels of care to the POA and that what was best for the resident was a level 1 or 2. Otherwise, the resident should go back to the hospital to find out what was wrong. She indicated that she did not feel Resident #001 would be a good candidate for CPR. She indicated that she was very frustrated with the POA because he/she was not understanding her explanation and she turned around and said "it's like talking to a brick wall". She further stated that she did not say that Resident #001 could not come back, but that this was the POA's interpretation of what she was saying. She said that in hindsight she should have put the papers away right then. She indicated that Resident #001 was returned to a level 4 the next day. Inspector asked when the level of care form was signed relative to when the resident came back to the home and she said she couldn't remember exactly but that it was around the same time.

A copy of the Management of Serious or Worsening of Condition document that was signed by Resident #001's POA "under duress" was obtained. This document, the information gathered during the inspection and the fact that Resident #001's level of care was changed back to a level 4 the next day, supports that the POA was made to feel they had to sign the document or the resident would not be re-admitted to the home. [s. 83. (1) (a)]

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 no person is told or led to believe that a prospective resident will be refused admission or that a resident will be discharged from the home because a consent or directive with respect to treatment or care has been given, not given, withdrawn or revoked, to be implemented voluntarily.

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

Issued on this 8th day of January, 2016

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

Original report signed by the inspector.