Ontario

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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 27, 2019	2019_559142_0020	013982-19	Complaint

Licensee/Titulaire de permis

MARIANHILL INC.
600 Cecelia Street PEMBROKE ON K8A 7Z3

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

Marianhill Nursing Home
600 Cecelia Street PEMBROKE ON K8A 7Z3

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

JANET MCPARLAND (142)

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 17 and 18, 2019.

Log #013982-19 was inspected related to resident care concerns.

During the course of the inspection, the inspector(s) spoke with a resident and their spouse, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Unit Manager, Social Worker (SW), Director of Care (DOC), and the Administrator. In addition, a review of a resident health record was conducted.

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 resident #001, alternatives to discharge had been considered and tried, that the resident and any person the resident directed them to keep informed, that is resident #001 spouse, were given the opportunity to participate in the discharge planning and provided with a written notice 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.

In review of resident's health record and in discussion with staff, it was noted that resident was non-compliant with a specific Licensee policy. On an identified date, resident approached the SW and indicated that they wanted to move to another location. On an identified date, the SW spoke with the resident's spouse in regards to transfer to the alternate location and the spouse indicated that they did not like the location for a number of reasons. The spouse further indicated that the resident liked it at Marianhill and that they would eventually require long-term care so did not want to move. On an identified date, during a resident/family care conference, discussion was held regarding resident's non-compliance with a specific Licensee policy.

In review of resident progress notes and in discussion with staff, it was noted that resident was not complying with a specific Licensee policy. On an identified date, the DOC spoke with resident regarding discharge from the home as a result of their non-compliance with the Licensee policy for an alleged incident in the home on a specific date. The resident requested the DOC contact their spouse to discuss the discharge plans. The DOC indicated to the resident and spouse that the resident would be discharged from the home mid-week and that arrangements would be made with the Champlain LHIN for services. A physician order was obtained on an identified date to discharge the resident home. It was further indicated in the progress notes that on the following day, the SW spoke with the resident's spouse who was reluctant to take the resident home. When the SW further explored the option of taking the resident to an alternate location, the spouse raised concerns about the alternative arrangements. A second location was agreed to by the resident and their spouse, but the alternative arrangement was not tried by the resident.

In discussions with Administrator, Director of Care, Social Worker and Unit Manager, they all indicated that discussions regarding discharge first occurred in an identified month when resident was non-compliant with the Licensee policy, however, there were no further discussions with the resident regarding discharge until an identified date,when a decision was made that the resident would be discharged.

In review of the resident's health record and in discussion with staff, the resident and their spouse, there was no indication that alternatives were tried or that the resident and their spouse were given the opportunity to participate in the discharge planning. Furthermore, on an identified date, during an interview with Inspector #142, the Administrator indicated that the resident was not provided with written notification prior to discharge of the resident. [s. 148. (2)]

Issued on this 27th day of August, 2019

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

Original report signed by the inspector.