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 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
Apr 3, 2019	2019_770178_0005	003882-19	Complaint

Licensee/Titulaire de permis

North Renfrew Long-Term Care Services Inc.
47 Ridge Rd DEEP RIVER ON K0J 1P0

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

North Renfrew Long-Term Care Services
47 Ridge Road P.O. Box 1988 DEEP RIVER ON K0J 1P0

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

SUSAN LUI (178)

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): March 22, 29, 2019.

This inspection pertains to Log #003882-19, a complaint regarding the withholding of approval of admission to respite care.

During the course of the inspection, the inspector(s) spoke with an applicant for admission to the home, the Administrator, the Manager/Director of Care, a Registered Nurse (RN), a personal support worker (PSW).

During the course of the inspection, the inspector also observed and tested the home's communication and response system, reviewed resident health records, and reviewed home records, including written communication between the Administrator and the complainant, a record of the call bell history in the home's respite room, and home records of resident to resident altercations.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

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 LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Findings/Faits saillants :

1. The licensee has failed to approve the applicant's admission to the home, without evidence that the home lacks the physical facilities necessary to meet the applicant's care requirements.

This noncompliance is related to Complaint Log #003882-19.

On March 22, 2019, applicant #001 indicated to inspector #178 that they had applied for a respite or short-stay admission to the long-term care home, but were rejected. Applicant #001 indicated that the reasons provided for the rejection were that the home lacked the facilities to care for the applicant, and that applicant #001 had been disruptive during previous short-stay admissions, which the home claimed put other residents at risk. Applicant #001 maintained that the home has the facilities to care for them, and has done so on multiple previous short-stay admissions. Applicant #001 indicated, however, that they do not like the home's new nurse call system, which does not go directly to the personal support worker (PSW). Instead, when a resident rings the bell it goes to the nurses' desk, and the nurse then contacts the PSW. Applicant #001 indicated that during their most recent short-stay admission, they often had to wait longer than they would like for staff to answer the call bell. Applicant #001 indicated that in spite of this, they applied for another short-stay admission to provide their caregiver with respite from caregiving duties. Applicant #001 also indicated that they disagree with the home's statement in the rejection letter that applicant #001 has been disruptive in the past, or that they present a risk to other residents.

Inspector #178 reviewed the letter of rejection sent to applicant #001 by the Administrator. The letter indicated that approval of the application for admission to the Respite Unit was being withheld, as per the Long-Term Care Homes Act (LTCHA) section 44 (7) (a), which states that the long-term care home lacks the physical facilities necessary to meet the applicant's care requirements. The letter described multiple complaints from applicant #001 about the home's nurse call system during their most recent short-stay admission, and indicated that on an identified date, applicant #001 indicated that they would not be returning because the home, according to applicant #001, could not meet applicant #001's needs regarding the nurse call system and various other complaints. The letter noted that applicant #001 cancelled a previously booked Respite stay, and indicated that the reason provided by applicant #001 was that the home's nurse call system does not meet applicant #001's needs. The letter also indicated that during the most recent short-stay admission, applicant #001 had altercations with two long-stay residents. The letter indicated that one of these verbal altercations escalated quickly, and staff expressed concern that there would have been physical violence if staff had not intervened. The letter indicated that the home does not have the physical facilities to prevent these altercations, as Respite clients use the same leisure and dining facilities as long-stay residents. The letter indicated concern that applicant #001's behaviours may result in violence between them and other residents.

On March 22, 2019, Inspector #178 interviewed the Administrator. The Administrator indicated that during their most recent short-stay, applicant #001 complained to multiple staff members that the home's call system does not meet their needs, and it is on this basis that approval of the most recent application for respite or short-stay was withheld. The Administrator indicated that the call bell system meets the needs of other residents and meets the standards in the LTCHA. The Administrator further indicated that during their most recent short-stay, applicant #001 engaged in verbal altercations with two different long-stay residents. One of these altercations escalated quickly, but staff intervened before it became physical. The Administrator indicated that the dining room and activity space is shared between respite and long-stay residents, and applicant #001 mobilizes independently, so it is not possible to keep applicant #001 separate from the long-stay residents. The Administrator indicated that because the home lacks the space to separate short-stay residents from long-stay residents, they lack the physical facilities to meet the care needs for applicant #001.

On March 22, 2019, Inspector #178 interviewed the Manager/Director of Care (DOC). The DOC indicated that staff had reported that during their most recent short-stay

admission, applicant #001 was involved in verbal altercations with two long-stay residents, and that staff felt that one of these altercations would have escalated to a physical altercation had staff not intervened. The DOC indicated that there is concern that if staff is busy in some other area of the unit, they may not be able to intervene in time to prevent escalation of a resident to resident altercation between applicant #001 and another long-stay resident. The DOC further indicated that applicant #001 has complained about the response time to call bells in the past, and that often applicant #001's idea of the length of response time and the actual response time were different. The DOC indicated that the respite apartment where applicant #001 has stayed is on the 2nd floor of the home, and contains three call bells: one at the bedside, one in the bathroom, and one in the living area of the apartment. All three bells ring at the nurses' desk, and the origin of the bell shows on a monitor at the nurses' desk. The bell would be seen by anyone who was at or passing by the desk, and would be heard throughout the unit. The bell would then be answered by the staff member who heard or saw the call, or would be communicated to the person assigned to the second floor. The system allows a person at the monitor to speak to the person who rang the call bell to determine their needs, but the bell can only be terminated at the place where it was activated.

No evidence was presented during this inspection to indicate that the home lacks the physical facilities necessary to meet applicant #001's care requirements. While applicant #001 previously complained about staff response time, there is no evidence to indicate that the home's communication and response system fails to meet the standards in the LTCHA. Evidence was presented that during their most recent short-stay admission, applicant #001 was involved in two verbal resident to resident altercations. However, no evidence was presented to indicate that applicant #001 has had physically responsive behaviours during their multiple short-stay admissions. [s. 44. (7) (a)]

Issued on this 8th day of April, 2019

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

Original report signed by the inspector.