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
Oct 8, 2019	2019_685648_0017	002868-18, 006081-18, 013106-18, 032784-18, 001577-19, 009128-19, 011110-19, 011232-19, 011238-19, 011540-19	Complaint

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Rockcliffe Care Community
3015 Lawrence Avenue East SCARBOROUGH ON M1P 2V7

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

JOVAIRIA AWAN (648), ANGIEM KING (644), SUSAN SEMEREDY (501)

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): August 27, 28, 29, 30, September 4, 5, 6, 9, 10, 11, 12, 13, 16, 17, 18, 19, 20, 23, 24, 25, 26, 2019

During the course of this inspection, the following complaint intakes were inspected:

Log #002868-18/IL-55400-TO
Log #006081-18/IL-56202-CE
Log #013106-18/IL-57377-CE
Log #032784-18
Log #001577-19/IL63602-CE
Log #009128-19/IL-66541-CE
Log #011110-19
Log #001232-19
Log #011238-19
Log #001540-19/IL-67420-CE/IL-67513-CE/IL-67726-CE

The following intakes were inspected concurrently within the complaint inspection:
Log #010238-19/Critical Incident System #2131-000037-19
Log #008268-19/Critical Incident System #2131-000030-19

During the course of the inspection, the inspector(s) conducted observations of medication administration pass times, staff and resident interactions, record review of health records, staffing schedules, home's investigation record, and relevant policies and procedures.

Inspector Asal Fouladgar, #751, was on-site training during this inspection September 4 to 13, 2019.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Registered Dietitian (RD), Physiotherapist (PT), Recreation Assistant (RA), Director of Resident Programs (DRP), Director of Environmental Services (DES), Maintenance Technician (MT), Housekeeping Deep Cleaners (HDC), Assistant Director of Care (ADOC), Director of Care (DOC), Executive Director (ED), and Central East Local Health Integration Network Senior Manager (CELHIN SM)

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **6 WN(s)**
- **3 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

The Ministry of Long-Term Care (MLTC) received a complaint from resident #013's substitute decision-maker (SDM) regarding the resident falling due to an equipment issue. According to the SDM, resident #013 did not have their required equipment.

A review of resident #013's health record indicated the resident was admitted to the home with an identified diagnosis and an assistive device was provided. The resident was identified to have impaired cognition, were dependent on assistance for mobility, and required an identified personal assistive device (PASD).

A review of progress notes indicated on an identified date, Physiotherapist (PT) #103 completed a safety assessment to remove the PASD for resident #013. According to this note, the resident was at an identified risk for falls. Since the resident was at the identified risk for falls, no alternatives were to be added. A previous note on an identified date, indicated the SDM was informed about the removal of the PASD and had consented. A further note on an identified date, indicated the resident's family was adamant that the resident needed the PASD as it assisted the resident for mobility and served as a falls prevention measure. The SDM signed a consent for the PASD and a maintenance request was sent to add the PASD for resident #013. On an identified date, a progress note indicated resident #013 fell out of their bed with no injuries. On the same day, PT #103 documented a post fall assessment and noted that the resident had a part

of the PASD missing.

An interview with Registered Practical Nurse (RPN) #127 indicated they recalled resident #013's family being adamant that the resident needed the PASD because it assisted with mobility and prevented falls. An interview with PT #103 indicated they usually put the identified PASD concurrently with another identified PASD. The PT recalled resident #013 fell out of the bed which was missing part of the PASD intervention. An interview with the Director of Environmental Services (DES) #119 indicated they recalled that at that time the home did not have equipment to provide the full PASD for the residents and it was applied partially.

An interview with Assistant Director of Care (ADOC) #105 acknowledged that resident #013's family wanted full application of the PASD for the resident but was not aware why it was only partially applied at the time of the resident's fall.

The home was aware the family strongly desired resident #013 to have the identified PASD applied fully but failed to ensure that the plan of care was based on this need and preference. [s. 6. (2)]

2. The licensee failed to ensure that if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

The MLTC received a complaint from a family member regarding resident #012 receiving improper care. An interview with this family member indicated the family was most concerned about falls sustained by resident #012.

A review of resident #012's medical record indicated the resident was admitted to the home on an identified date. A progress note dated on an identified date, indicated the resident had a fall and the family was aware of the resident's behaviour identified to be contributing to the fall. A review of post fall assessments from over an identified period indicated the resident had numerous falls of which the majority were related to the identified behaviour. There were no significant injuries identified related to these falls. Review of the resident's current plan of care indicated the resident was at an identified risk for falls related to the identified behaviour. Approaches to respond to this risk include identified interventions.

Further review of the resident's progress notes for an identified date indicated that, the

physician reviewed diagnostic report and confirmed that the resident had specified injuries and noted that the resident has had multiple falls over the past couple of months often because of their identified behaviour. A post fall progress note on an identified date, indicated the resident's POA was upset stating that the staff are not doing enough to prevent the resident from falling.

An interview with RPN #106 indicated resident #012 had expressed the identified behaviour since their admission and recently had considered interventions to address the identified behaviour. An interview with physician #128 confirmed the identified behaviour existed for resident #012. The physician indicated that nursing mentioned the falls were more related to the behaviour and that the fractures may have resulted from falls.

An interview with ADOC #105, who is the lead for the home's falls prevention and management program, acknowledged that resident #012 had several falls since admission and the home had not considered other contributing factors such as the identified behaviour contributing to the residents falls risk. The ADOC confirmed the home should have considered interventions to address this identified behaviour as the resident continued to fall for a lengthy period prior to it being considered.

The home failed to consider different approaches when reviewing and revising resident #012's plan of care related to falls. [s. 6. (11) (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 care set out in the plan is based on an assessment, needs and preferences of that resident; and if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: 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. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that devices for the falls prevention and management program were readily available at the home.

The MLTC received a complaint from a family member regarding resident #012 receiving improper care. An interview with this family member indicated the family was most concerned about the amount of falls resident #012 has had.

A review of resident #012's medical record indicated that the resident was admitted to the home on an identified date. A review of post fall assessments over an identified period of time indicated the resident had numerous falls during this time, of which the majority were related to the an identified behaviour expressed by the resident. Review of the resident's current plan of care indicated the resident was at an identified risk for falls related to the identified behaviour. Approaches to respond to were identified in the plan of care.

A review of progress notes indicated RPN #102 documented on an identified date, that resident #012 continues to ambulate themselves to their room and the resident knows how to remove the their clip on safety alarm. A request was sent to maintenance for a falls prevention intervention for the residents wheelchair.

A progress note dated on an identified date, indicated resident #012 had a fall in their room. According to their roommate, the resident attempted to self transfer, resulting in a fall. A post fall assessment note written by PT #103 on an identified date, indicated they asked an ADOC to order the falls prevention intervention for the residents wheelchair as they were able to remove the clip on the safety alarm to self-transfer.

Another progress note written by RPN #102 on an identified date, stated resident #012 was noted to have attempted personal care without assistance and was able to remove the clip on safety alarm. The note indicated they sent a request to the PT and the ADOC for the falls prevention intervention for resident #012's wheelchair.

Further progress notes indicated resident #012 had a fall on an identified date, and was found by their PSW. On the same day, later on in the shift, resident #012 was found on the floor by PSW staff, having been alerted by a roommate. A post fall assessment note written by PT #103 related to this fall indicated they asked the ADOC to order the falls prevention intervention for resident #012's wheelchair as they remove the wheelchair clip on safety alarm to self-transfer. Additional progress notes indicated resident #012 had falls on subsequent identified dates, and the PT again stated they asked the ADOC to order the specified falls prevention intervention for the wheelchair in their post fall assessments on the same dates correlating to the residents falls.

An interview with RPN #102 indicated they were told the specified falls prevention intervention requested by PT for wheelchairs were not available at this home. An interview with PT #103 indicated they spoke with ADOC #105 regarding the falls prevention intervention for wheelchairs and was told that they would check with the DOC to see if there was a budget for these. An interview with ADOC #105 indicated that the home could not single out resident #012 for the falls prevention intervention as they had to see if other residents might be able to benefit from such a device.

Observations conducted during the inspection period, indicated resident #012 had a chair clip and safety alarm in place at the time.

A review of Maintenance Care records indicated that an identified task was created on an identified date, related to resident #012's bed alarm. According to this record, the task was resolved on a subsequent date. A progress note identified that resident #012 had a fall on an identified date at an identified time, and was found with no apparent injuries. A further progress note document for later that day, indicated the SDM was contacted regarding the fall and was concerned that the fall prevention item was not working. An interview with RPN #102 indicated the specified fall prevention items are often "hard to find."

An interview with DES #119 indicated the reason the specified fall prevention item was not fixed until multiple days later as that they did not have any extra supplies available and had to take a part from another older model fall prevention item. The DES stated that the home had recently ordered extra supplies of the specified fall prevention item to be on hand but at that time, they did not have any extras. An interview with ADOC #105 acknowledged that the specified fall prevention item the home uses are often out of stock.

The home failed to ensure that specified items for the falls prevention and management program were readily available at the home. [s. 49. (3)]

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 devices for the falls prevention and management program are readily available at the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures are developed and implemented to ensure that all equipment, devices, assistive aids, and positioning aids in the home are kept in good repair.

The MLTC received a written complaint by resident #033's SDM indicating concerns related to the implementation and staff response to falls prevention and management strategies.

Inspector #648 interviewed resident #033's SDM prior to initiating the inspection. Resident #033's SDM identified the resident was at risk of falls with falls prevention strategies in place including an identified device. The SDM reported that they visited the resident routinely, and had reported the identified device was provided to the resident but did not demonstrate proper functioning during their visits. The SDM reported they had not

observed staff check the device for appropriate function or status of good repair during their frequent visits to the home.

On an identified date and time during the course of this inspection, an observation conducted of resident #003 and their identified device with PSW #121 confirmed the device had been applied incorrectly and was not functional. PSW #121 confirmed the device did not engage when activated and was not functional at the time of the observation. PSW #121 was unable to demonstrate how long the device had been this way prior to the observation with the inspector. Inspector #648 spoke to resident #033's SDM during this observation, and the SDM confirmed the device did not engage. An observation conducted of resident #033's identified device at a later time and date during the course of this inspection with the homes DES and RPN #144 identified the device had not been applied correctly at the time of the subsequent observation., and confirmed it would not function adequately as a falls prevention and management intervention.

Interview with RPN #136 stated there was no formal process they were aware of in the home that identified preventative maintenance to ensure devices used by residents in the home were functional for residents identified at risk of falls. RPN #136 queried if PSW staff were to check the devices but could not confirm. RPN #136 stated they were unaware of any issues reported for resident #033's identified device.

Interview with the homes DES indicated PSW staff were responsible for informing maintenance staff of non-functional devices used for residents in the home at risk of falls. The DES reported no maintenance requests had been made related to resident #033's identified device. The DMS was unable to demonstrate a process for preventative maintenance for the identified device to ensure they were functional and applied appropriately.

Review of resident #033's plan of care at the time of the inspection identified them to be at risk of falls and required the identified device to manage this risk.

Above observations and interviews with the homes staff and SDM were reviewed with ADOC #105. ADOC #105 confirmed resident #033 required the identified device as a falls prevention and management strategy for their identified risk of falls. ADOC #105 acknowledged the home did not have a process in place to ensure that such devices in place for residents at risk of falls were functional and applied appropriately. The ADOC acknowledged the home failed to ensure that procedures are developed and implemented to ensure that all equipment, devices, assistive aids, and positioning aids.

[s. 90. (1) (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 procedures are developed and implemented to ensure that all equipment, devices, assistive aids, and positioning aids in the home are kept in good repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to fully respect and promote the resident's right to give or refuse consent to any treatment, care or services for which consent is required by law.

The MLTC received a complaint log on an identified date identifying resident #031 by the complainant (SDM). Resident #031's SDM reported the home would adjust the residents course of treatment without their consent.

Review of the homes policy, Change of Status - Notification of POA/Family (#VII-A-10.20, May 2019) stated that the SDM shall be notified of changes affecting the resident to ensure ongoing communication between the inter professional care team and the SDM. The policy further identified documentation will be made in progress notes and shall include at minimum, date and time of contact made/or attempts to contact and name of the person to whom the notification was provided.

Review of resident #031 physicians orders identified the following three instances of treatment changes and supplementary documentation which did not demonstrate documentation indicating the residents' SDM had been notified of the change in treatment. .

Interview with RN #120 confirmed the resident #031's treatment changes were implemented for the resident as documented. RN #120 stated staff were required to sign off on consent in the treatment change documentation in addition to when it was obtained after contacting a residents SDM. Resident #031's treatment changes identified in their clinical records were reviewed with RN #120. RN #120 was unable to demonstrate that resident #031's SDM had provided consent for the identified changes in their course of treatment.

Interview with ADOC #139 identified that nursing staff in the home are expected to contact a residents SDM within 24 hours to inform them of changes in medication change. The ADOC #139 reported SDM's are to be contacted directly through a phone call, and documentation of a progress note is required to demonstrate the communication had been made in addition to documenting on the physicians order sheet in the consent form box. Staff interviews and resident #031's treatment changes as noted above were reviewed with ADOC #139. ADOC #139 acknowledged the homes policy was not followed, and was unable to demonstrate that the home fully respected and promoted resident #031's SDM's right to give or refuse consent for the identified changes. [s. 3. (1) 11. ii.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee failed to ensure the registered dietitian in the home completed a nutritional assessment for the resident when there was a significant change in the resident's health.

The MLTC received a complaint log on an identified date related to resident #032 identifying concerns related to a change in the residents nutrition. The complainant reported that the licensee did not provide adequate assistance to resident #032 and they were not informed of a change in their nutrition.A critical incident system report (CIS) submitted by the home on a subsequent date, while resident #032 was hospitalized, identified the home was made aware of an allegation of neglect related to nutrition concerns for resident #032. The CIS was inspected within this complaint log.

Review of resident #032's written plan of care indicated d they were at an identified nutrition risk. The written plan of care included interventions to promote optimal nutrition status per their identified risk including a modified diet and oral nutritional supplementation.

Review of resident #032's nutrition monitoring documentation identified the resident routinely accepted meals offered prior to their hospitalization. A referral was sent to the homes dietary department related to resident #032'S return from hospital the same day. The homes RD followed up on the referral after resident #032 had been readmitted to hospital, and did not assess the resident as they were not available at this time.

In between hospitalizations, resident #032 was identified to have had a significant weight loss of 5% of more over a period of one month. Review of resident #032's nutrition monitoring documentation identified a significant change in their pattern of intake at meals after their initial hospitalization. A dietary referral related to these changes was not identified in the residents clinical records.

Review of the homes policy "Referral to Dietitian" (VIII-D-10.10, May 2019) identified that nursing will assess all residents for nutritional risk factors and complete a Dietary Referral to the RD as necessary in cases such as:
- weight loss/gain: criteria triggered at 5% change in 30 days, or an undesirable weight change that compromises resident's health status.
- unplanned inadequate food intake/appetite experienced for three or more days; food - consistently less than 50% consumed at and between meals
- diet needs to be reassessed as a result of changes in health status, return from hospital.

Interview with RN #136 confirmed a referral had not been sent to the RD related to residents #032 significant change in nutrition status as identified above.

Resident #032's clinical records as noted above were reviewed with the homes RD. The RD iterated the referral pathway as outlined in the homes policy, stating a RD referral is required for residents identified with a significant weight change, or an identified significant change in their nutrition. The RD reported referral follow up was determined through priority of weight loss, change in appetite, or change in skin within a week of receiving the referral. The homes RD confirmed the initial referral sent to the dietary department was for the residents return from hospital did not identify a significant change. Resident #032's change in nutrition in between their hospitalizations were reviewed with the RD. The RD stated a dietary referral was warranted, as the information demonstrated a significant change in the residents nutrition but they did not receive the referral as per the homes policy, and had not assessed resident #032 prior to their subsequent hospitalization for their nutrition and hydration risks.

Resident #032's clinical records, staff interviews, and the homes policy was reviewed with ADOC #105. ADOC #105 acknowledged the homes policy was not followed and resident #032 was not assessed by the RD for their significant change related to nutrition and hydration risks. [s. 26. (4) (a),s. 26. (4) (b)]

WN #6: 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).

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home approved the applicant's admission to the home unless the home lacked the physical facilities necessary to meet the applicant's care requirements.

Central East Local Health Integration Network (CELHIN) sent a copy of a letter with an identified date, that had been sent to applicant #014 to the MLTC indicating Rockcliffe Care Community was denying admission. A review of this letter indicated it was written by the Long-Term Care (LTC) home's DOC #147 stating the home lacked the physical

facilities to meet applicant #014's care needs.

During an interview with DOC #147, they indicated the home could not manage the applicant's care needs.

A copy of admission documents that were sent to the home was attained from CELHIN and reviewed, and indicated the applicant did not have the specified responsive behaviours. The documents identified the resident was completing their course of treatment, and were stable and cooperative.Responsive behaviours were not identified for the resident.

During an interview with CELHIN senior manager (SM) #159 they indicated that the home did not have reasonable grounds to deny applicant #014's admission. According to the SM, they were not under the impression applicant #014 required a different setting than what the home had to offer. In this case, the SM did not feel the home was clear as to the reason why the physical facility would not work for the applicant as there was nothing in their history to indicate an inability to get along with others.

The home failed to demonstrate how they lacked the physical facilities necessary to meet the applicant's care requirements. [s. 44. (7) (a)]

2. The licensee has failed to ensure that if the licensee withholds approval for admission, the licensee shall give to the applicant a written notice setting out an explanation of how the supporting facts justify the decision to withhold approval.

Central East Local Health Integration Network (CELHIN) sent a copy of a letter to the MLTC that had been sent to applicant #014 indicating Rockcliffe Care Community was denying admission. The letter was dated December 25, 2018.

A review of this letter indicated it was written by the Long-Term Care (LTC) homes DOC #147 stating the home lacked the physical facilities to meet applicant #014's care needs.

During an interview with DOC #147, they indicated the home could not manage the applicant's behaviours because the facility does not have the space to accommodate and separate residents with behaviours.

During an interview with CELHIN senior manager (SM) #159, they indicated that the home did not have reasonable grounds to deny applicant #014's admission. The SM

agreed that space at the home was an issue but further stated there needed to be caution related to blanket denials related to lack of space or physical layout. In this case, the SM did not feel the home was clear as to the reason why the physical facility would not work for the applicant.

The home withheld approval for admission of applicant #014 and failed to give the applicant a written notice setting out a detailed explanation of how the supporting facts justify the decision to withhold approval. [s. 44. (9) (c)]

Issued on this 1st day of November, 2019

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

Original report signed by the inspector.