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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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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
Mar 21, 2016	2015_393606_0015	018915-15	Complaint

Licensee/Titulaire de permis

The Regional Municipality of York
17250 Yonge Street NEWMARKET ON L3Y 6Z1

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

YORK REGION NEWMARKET HEALTH CENTRE
194 EAGLE STREET NEWMARKET ON L3Y 1J6

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

JANET GROUX (606)

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, 14, 15, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Supervisor of Care (SOC), Social Worker (SW), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and Substitute Decision Maker (SDM).

During the course of the inspection, the Inspector conducted observation of residents and home areas, staff to resident interactions, reviewed clinical health records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident’s plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the resident’s substitute decision-

maker, if any, and any other persons designated by the resident or substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident’s plan of care.

Review of a complaint intake identified concerns regarding resident #001's medication administration, notification of a change in the resident's condition, and readmission to the home after hospitalization.

Review of an identified home's policy indicated bringing any discrepancies to the attention of the physician and other members of the health care team; any discrepancies should be identified and resolved through collaboration with the health care team, including resident/family, physician, pharmacist, and registered staff.

Review of resident #001's progress notes revealed that the resident's substitute decision maker,(SDM) provided the home in writing on an identified date an updated physician's order for an identified medication, and informed the home that the medication order that he/she provided on the identified date, was inaccurate.

Review of the resident #001's admission orders on the identified date, indicated:
-administer the identified medication 25mg by mouth once daily;
-discontinue the identified medication 50mg half to one tablet by mouth nightly at bedtime.

Review of a written document submitted on an identified date, by the SDM indicated:
-administer identified medication 50mg one to one and a half nightly after dinner.

Interview with the SDM revealed that he/she provided the home the correct medication order in writing and confirmed that the home received this written document on the identified date.

Interview with RPN #100 revealed that the physician was notified via telephone regarding the above mentioned medication change and received no change to resident #001's current medication orders and confirmed that the SDM was not notified of this.

Interview with SOC #101 revealed that the SDM should be a part of this decision and should have been notified of the physician's order and confirmed this was not done. [s. 6. (5)]

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 resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident’s plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Review of an identified home policy indicated all incidents involving residents exhibiting aggressive behaviours are to be referred to the resident's attending physician and the attending psychiatrist for follow-up and treatment.

Review of Resident #001's progress notes indicated four incidents of responsive behaviours towards staff.

Interview with the RPN revealed that the home's practice is to complete behavioural tracking for seven days, notify the physician and refer to the BSO team and this was not followed.

Interview with ADOC confirmed that the home's policy, was not followed. [s. 8. (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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: 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), the licensee shall, (a) ensure that alternatives to discharge have been considered and, where appropriate, tried; (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; (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 (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.

Review of resident #001's progress notes revealed the resident was admitted to the home on an identified date, and was expected to be discharged on an identified date. However, resident #001 was transferred to the hospital for an assessment of a medical

condition and injury sustained from an incident in the home on an identified date.

On the evening of an identified date, resident #001's SDM informed the home that resident #001 was expected to be transferred back to the home and was waiting on transportation but the transfer was cancelled due to the resident exhibiting responsive behaviour.

A conversation earlier that day between the ADOC and the SDM regarding the resident's responsive behaviours indicated the home's plan to refer resident to the Behavioural Support of Ontario (BSO) Program. The SDM was in agreement of this plan and informed the home that he/she would not be available until an identified date, as he/she was going out of town.

Further review of the progress notes indicated that on an identified date, an identified staff from the hospital notified the home that the resident displayed responsive behaviours while in the hospital and the physician had assessed and made changes to his/her medications, and that the resident would be discharged back to the home. However, the hospital was informed by the home via voice message from an identified staff that the directions from the Administrator, the Director of Care (DOC), and the placement coordinator from the Community Care Access Centre (CCAC), that the resident was discharged from the home to his/her home in the community.

Interview with the SDM revealed he/she was not involved in the decision to discharge resident on the identified date, and did not receive written notification of the discharge. The SDM also indicated the home did not offer resident #001 an alternative placement to discharge. Resident #001 was discharged back into the community in the care of the SDM.

Interview with identified staff at the CCAC revealed the following:
- CCAC provided LTC home with recommendations via voice mail until another placement was confirmed;
- CCAC did not receive a call back from the home prior to the home discharging the resident on the identified date.

Interview with the SW and the Administrator revealed the home discharged resident #001 from the home due to the resident's safety risk to himself and others and the home not being able to provide care to the resident related to his/her responsive behaviours. The home confirmed resident #001 was not offered an alternative to discharge, the SDM was

not given opportunity to participate in the discharge, and did not notify the SDM in writing of the discharge. [s. 148. (2)]

Issued on this 31st day of March, 2016

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

Original report signed by the inspector.