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

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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 6, 2018	2018_435621_0009	005971-18	Complaint

Licensee/Titulaire de permis

Corporation of the Town of Kirkland Lake
3 Kirkland Street West Postal Bag 1757 KIRKLAND LAKE ON P2N 3P4

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

Teck Pioneer Residence
145A Government Road East Postal Bag Service 3800 KIRKLAND LAKE ON P2N 3P4

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

JULIE KUORIKOSKI (621)

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 29, 2018, and April 3 -5, 2018.

This Complaint Inspection was conducted offsite regarding a complaint concerning an inappropriate discharge of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (Administrator/DOC), the Assistant Director of Care (ADOC), a Registered Practical Nurse (RPN), a Placement Coordinator from the North East Local Health Integrated Network (NE LHIN), and a resident's family member. The Inspector also reviewed relevant resident care records.

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)**
- **1 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 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,
(a) Ensured that alternatives to discharge had been considered and, where appropriate, tried;
(b) In collaboration with the appropriate placement coordinator and other health service organizations, made alternative arrangements for the accommodation, care and secure environment required by the resident;
(c) Ensured the resident and the resident's substitute decision maker, if any, and any person either of them may direct was kept informed and given opportunity to participate in the discharge planning and that his or her wishes were taken into consideration; and
(d) Provided 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 related both to the home and to the resident's condition and requirements for care, which justified the licensee's decision to discharge the resident.

A complaint was submitted to the Director on a specific day, which indicated that resident #001 was sent to hospital and subsequently discharged by the home without the

complainant's knowledge.

During an interview with the complainant on another specific day, they reported to Inspector #621 that they were resident #001's substitute decision maker (SDM), and that resident #001 had been admitted to the home on a specific day in March 2018. The SDM indicated that within a certain amount of time after leaving the home that day, they were called back due to a responsive behaviours incident involving resident #001. The SDM further reported that the Administrator of the home made it known to the SDM that they were sending the resident to hospital, but did not communicate that they were discharging the resident from the home. The SDM stated that they only became aware that the resident had been discharged after hospital staff informed them. The SDM reported to the Inspector that at no time prior to the discharge had the home given them the opportunity to be involved in the discharge plan, nor had the home provided them with a written letter of discharge explaining why the home had discharged the resident. The SDM reported that they believed that the home had not completed any assessments of the resident, nor tried any strategies to manage this resident's responsive behaviours before making a unilateral decision to discharge the resident.

During an interview with RPN #100 on a day in April 2018, they reported to Inspector #621 that they had admitted resident #001 on a specific day in March 2018. The RPN identified that the resident began exhibiting certain responsive behaviours after the SDM left the home, and during a specific time period thereafter, the responsive behaviours escalated. The RPN identified they had not had time to try other strategies to mitigate the resident's responsive behaviours before the home's Administrator contacted certain outside agencies, with the resident subsequently escorted to hospital.

During an interview with the North East Local Health Integration Network (NE LHIN) Placement Coordinator #101 on a day in April 2018, they identified to Inspector #621 that they were involved in resident #001's placement. Placement Coordinator #101 indicated that the home admitted the resident on a specific day in March 2018, and at no time thereafter did the home contact them to discuss strategies to manage this resident's responsive behaviours before sending a discharge notification. Finally, Placement Coordinator #101 reported to the Inspector that typically homes communicate with them when there are issues that arise on a resident's admission to help troubleshoot the situation.

During interviews with the Administrator/Director of Care (Administrator/DOC) on two specific dates in April 2018, they reported to Inspector #621 that they were responsible

for making the decision to discharge resident #001 from the home. The Administrator/DOC reported that their reasons for discharging the resident related to specified responsive behaviours. The Administrator/DOC also indicated that their rational for discharge also included the fact that home did not have a bed available in a specific home area to mitigate certain outcomes associated with this resident's responsive behaviours. The Administrator/DOC confirmed to the Inspector that prior to discharge of the resident to hospital the home had not tried alternatives to discharge, they had not collaborated with the home's placement coordinator to help troubleshoot the situation, nor did they make alternative arrangements for accommodation. Additionally, the Administrator/DOC confirmed that prior to discharge, they had not given the resident's SDM opportunity to participate in the discharge plan to enable the SDM to have their wishes considered. Finally, the Administrator/DOC confirmed to the Inspector that they had not provided the resident's SDM with a written letter of discharge, with facts to justify the home's decision to discharge the resident. [s. 148. (2)]

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 before discharging a resident under subsection 145(1), the licensee, (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 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, which justify the licensee's decision to discharge the resident, to be implemented voluntarily.

Issued on this 6th day of April, 2018

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

Original report signed by the inspector.