Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jan 23, 2020	2019_791739_0042	023798-19, 023799-19	Complaint

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

Chartwell Royal Oak Long Term Care Residence
1750 Division Road North KINGSVILLE ON N9Y 4G7

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

JULIE DALESSANDRO (739)

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): December 23, 2019, January 6, 7, 8, 9, and 10, and 20, 2020.

During the course of this complaint inspection the following intakes were reviewed related to discharge:
Log #023798-19 / IL-72970-LO
Log #023880-19 / IL-73020-LO
Log #023799-19 / IL-72972-LO

During the course of the inspection, the inspector(s) spoke with The resident's substitute decision maker, Personal Support Worker(s), the LHIN Placement Coordinator, the home's Director of Nursing, and the home's Administrator.

During the course of this inspection the inspector(s) also conducted clinical and non-clinical record reviews relevant to the inspection.

The following Inspection Protocols were used during this inspection:
Admission and Discharge

During the course of this inspection, Non-Compliances were issued.
- **2 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	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. 145. When licensee may discharge

Specifically failed to comply with the following:

s. 145. (2) For the purposes of subsection (1), the licensee shall be informed by,
(a) in the case of a resident who is at the home, the Director of Nursing and Personal Care, the resident's physician or a registered nurse in the extended class attending the resident, after consultation with the interdisciplinary team providing the resident's care; or O. Reg. 79/10, s. 145 (2).
(b) in the case of a resident who is absent from the home, the resident's physician or a registered nurse in the extended class attending the resident. O. Reg. 79/10, s. 145 (2).

Findings/Faits saillants :

1. The Long-Term Care Home Regulation 145 (1) states in part that, a licensee of a long-term care home may discharge a resident if the licensee is informed, by someone permitted to do so, that the resident's requirements for care have changed and that, as a result, the home cannot provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come into contact with the resident. O. Reg. 79/10, s. 145 (1).

The licensee has failed to ensure that in the case of a resident who was absent from the home, the resident's physician attending the resident informed the licensee that the resident's requirements for care had changed and that, as a result, the home could not provide a sufficiently secure environment to ensure the safety of the resident or the safety of other persons who come in contact with the resident and the licensee discharged the resident from the long-term care home.

A complaint from was received by the Ministry of Long-Term Care Info Line regarding the discharge of resident #001 from Chartwell Royal Oak Long-Term Care Home. The complainant stated that the home did not comply with the requirements of discharge for resident #001.

Record review of resident #001's health records was completed. The resident had incidents of responsive behaviours throughout their stay in the home, but those behaviours had significantly escalated in a specific month.

Record review of a hospital report indicated that Physician #105 (the hospital physician) assessed resident #001 in hospital and stated, in the report, that "hospitalization will not

provide any significant benefit". Physician #105 also recommended an urgent follow-up by an identified external support team within a week after the resident's discharge from hospital.

Record review of a letter from the home's physician #103 addressed to the Emergency Room stated in part that, the home was unable to take the resident back and they understood that hospital may not have been the most appropriate admission.

In a letter signed by the home's Administrator #100, it stated, in part, that the home had been informed by their physician #103 and DOC #101 that the home could not provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who came into contact with the resident. The letter concluded by indicating that discharge was the most appropriate alternative arrangement.

During an interview with the home's DOC #101, they stated that the home's physician discharged resident #001 from their care on a specific date while the resident was in hospital.

Resident #001, who was absent from the home and in hospital, was discharged by the licensee from the long-term care home, as informed by the home's physician #103 and not the resident's physician attending the resident in hospital. [s. 145. (2) (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 ensure that in the case of a resident who is absent from the home, the resident's physician attending the resident inform the licensee that the resident's requirements for care have changed and that, as a result, the home cannot provide a sufficiently secure environment to ensure the safety of the resident or the safety of other persons who come in contact with the resident., to be implemented voluntarily.

WN #2: 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) 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 and b) provide a written notice to the resident, resident's substitute decision-maker, and any other person they 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).

(A) Record review of specific meeting minutes indicated that a meeting was held and there was a "possibility of looking at other community resources". The form stated in part that, the Erie St.Clair Local Health Integration Network (ESC LHIN) was notified and aware that resident #001 may not have been a great fit for this home, however had not indicated a date in which the ESC LHIN Placement Co-ordinator was informed.

During an interview with ESC LHIN Placement Co-ordinator #102, they stated that they had been informed during a phone conversation on a specific date at a specific time, the

same day the resident was discharged, with the home's Administrator #100, that resident #001 had been transferred to hospital and the home would be discharging them.

During an interview with Administrator #100, Inspector #739 asked if the home had collaborated with the appropriate ESC LHIN Placement Co-ordinator and had made alternative arrangements for accommodating resident #001. Administrator #100 indicated that on the same day of discharge, in the morning, they had spoken to the ESC LHIN Placement Co-ordinator #102 and had told them that "the home would be discharging the resident unless there was a suitable placement or plan". Administrator #100 stated that they had spoken to a Placement Co-ordinator at the ESC LHIN prior to this date regarding alternate placement options however, when requested by inspector, Administrator #100 was unable to demonstrate when this conversation took place or what alternative arrangements were discussed during this phone call.

Record review of an e-mail communication sent by ESC LHIN Placement Co-ordinator #102 to Administrator #100, stated in part that a request had been made for an urgent teleconference which was to have been arranged on the day after the home discharged resident #001 to sort out "next steps" for the resident.

During an interview with Administrator #100 they acknowledged that there was a meeting held on a specific date to discuss other resources available for resident #001 however, the ESC LHIN Placement Co-ordinator #102 was not involved in this conference.

The home had failed to ensure that, in collaboration with the appropriate Placement Co-ordinator and other health service organizations, they had made alternative arrangements for the accommodation, care and secure environment required by the resident.

(B) Record review of the resident's clinical chart in PCC, indicted that resident #001 was discharged from the home on a specific date.

Record review of a letter indicated that the discharge letter was sent to the ESC LHIN Placement Co-ordinator #102 two days after the home had discharged the resident.

Record review of resident #001's progress note dated four days after the resident had been discharged from the home indicated that DOC #101 had spoken with the resident's (SDM) and that "they will receive a letter in the mail informing them about the resident being discharged from the home".

Record review of the mail carrier tracking form for the discharge letter sent to resident #001's SDM indicated that the letter was accepted at the post office seven days after the home's decision to discharge the resident, and had been sent out for delivery the following day.

During an interview with resident #001's SDM they stated that they were not made aware of the resident's discharge from the home until four days after the resident had been discharged when the home's DOC #101 called to inform them. Resident #001's SDM stated that they had not received a discharge letter.

During an interview with DOC #101 they confirmed that resident #001 was discharged from the home on a specific date and they did not receive a discharge letter, the LHIN was sent a discharge letter two days after the resident had been discharged, and resident #001's SDM was sent a discharge letter four days after the resident had been discharged.

The licensee had failed to ensure that they provided a written notice to the resident, resident's substitute decision-maker, and the ESC LHIN, that justified the licensee's decision to discharge the resident before discharging the resident to the hospital on the identified date. O. Reg. 79/10, s. 148 (2). [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 the licensee shall: a) 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 and b) provide a written notice to the resident, resident's substitute decision-maker, and any other person they 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., to be implemented voluntarily.

Issued on this 27th day of January, 2020

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

Original report signed by the inspector.