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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 22, 2018	2018_638609_0012	010075-17	Complaint

Licensee/Titulaire de permis

Spencer House Inc.
835 West Ridge Blvd ORILLIA ON L3V 8B3

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

Spencer House
835 West Ridge Blvd. ORILLIA ON L3V 8B3

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

CHAD CAMPS (609)

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): June 5-8, and 11-15, 2018.

This inspection was conducted as a result of a complaint submitted to the Director related to a resident's discharge from the home.

A Critical Incident (CI) inspection #2018_638609_0013 and a Follow Up inspection #2018_638609_0011 were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Director of Resident Programs, Physiotherapist, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and family members of residents.

The Inspector(s) also conducted a daily walk through of resident care areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' healthcare records, staff training records, internal investigations, policies, procedures, programs, and annual program evaluation 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)**
- **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	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 a resident was discharged under subsection 145 (1); that alternatives to discharge had been considered and, where appropriate, tried; that the resident and the resident's substitute decision-maker, if any, and any person either of them may direct was kept informed and given an opportunity to participate in the discharge planning and that his or her wishes were taken into consideration; and that they 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, that justified the licensee's decision to discharge the resident.

A complaint was submitted to the Director which alleged resident #001 was improperly discharged from the home after being sent to the hospital.

Inspector #609 interviewed the complainant, who outlined how during a meeting between hospital staff and the home, the home's leadership discharged the resident. This occurred days after they transferred the resident to the hospital.

a) Inspector #609 reviewed resident #001's health care records and found in progress notes that after a responsive behaviour incident the ED, DOC and the Medical Director (MD) decided to transfer the resident to the hospital for further assessment and treatment.

Another progress note just days later, found that during a meeting between the hospital and home staff to discuss resident #001's condition, the MD and DOC decided to discharge the resident related to responsive behaviours.

However, a review of health care records found that as far back as five months before resident #001 was discharged, the home identified in progress notes the resident's increased responsive behaviours.

A review of the home's policy titled "Responsive Behaviours- Management" current revision March 2018 required the ED and the DOC to determine the need for additional staffing supports for residents exhibiting responsive behaviours, like accessing the Ministry of Health's High Intensity Needs (HIN) funding.

During an interview with the ED and DOC, both verified that they had never applied for HIN funding before they decided to discharge resident #001.

During an interview with the complainant, they indicated that the home refused the hospital's request to postpone discharge, until they were able to ascertain if resident #001 could be stabilized.

A review of the home's policy titled "Resident Leave of Absence/Transfer/Discharge" current revision June 2016 indicated that residents were to be readmitted back to the care community from a medical/psychiatric leave. The policy also referenced the Regulation for time frames and specific guidelines the home was to follow around discharge.

During an interview with the DOC, they verified they were present during the meeting between hospital staff and the home to discuss resident #001's condition. The DOC verified that no alternatives to discharge were considered or tried between when the resident was admitted to the hospital for assessment and when the decision was made to discharge the resident.

b) Inspector #609 interviewed the complainant, who stated that resident #001 was not present at the meeting between home and hospital staff. The resident was not given any opportunity to participate in the decision to discharge, before they were discharged by the home.

A review of the home's policy titled "Resident Leave of Absence/Transfer/Discharge" current revision June 2016 referenced the Regulation for time frames and specific guidelines around discharge.

During an interview with the DOC, they verified that resident #001 was their own decision-maker, was not deemed incapable and that the resident was not involved in the meeting and subsequent discharged from the home.

c) Inspector #609 reviewed resident #001's health care records and could not locate any written notice to the resident, that set out a detailed explanation of the supporting facts, that justified the licensee's decision to discharge the resident.

During an interview with the ED and DOC, both verified that no written notice was provided to resident #001 before or after the resident was discharged from the home and that one should have been provided. [s. 148. (2)]

Issued on this 1st day of August, 2018

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

Original report signed by the inspector.