Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
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Original Public Report

Report Issue Date: August 14, 2024

Inspection Number: 2024-1466-0001

Inspection Type:
Complaint
Critical Incident

Licensee: Arirang Age-Friendly Community Centre

Long Term Care Home and City: Arirang Korean Long-Term Care, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 17, 18, 19, 22, 23, 29, 2024, and off-site on July 24 and 25, 2024.

The following intake was inspected in the Complaint Inspection:

- Intake: #00111081 was related to bed refusal

The following intakes were completed in the Critical Incident System (CIS) Inspection:

- Intakes: #00113942 and #00114767 were related to a fall of a resident resulting in injury

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Falls Prevention and Management
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the resident's plan of care was provided to the resident as specified in the plan.

A resident sustained a fall on a specified date and acquired an injury.

The written plan of care of the resident indicated staff to apply a specific device in good working order as an intervention for falls management. The staff was not able to confirm that the device was functioning properly when the resident fell.

Failure to ensure the resident was provided care as specified in the plan of care increased the risk of failed fall prevention.

Sources: Interview with home's staff; observation, and the resident's record review.

WRITTEN NOTIFICATION: Authorization for admission to a home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (7)
Authorization for admission to a home

s. 51 (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 50 (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;
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements;
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval.

The licensee has failed to comply with FLTCA s. 51 (7) whereby the licensee refused an applicant's admission to the home based on reasons that were not permitted in the legislation. Specifically, the licensee withheld the approval for the admission citing the reasons as: facility lacked the physical facilities, and the staff of the home lacked the nursing expertise necessary to meet the applicant's care requirements; circumstances existed which were provided for in the regulations as being a ground for withholding approval.

The Ministry of Long-Term Care (MLTC) received a complaint related to withholding an applicant's admission. The applicant had specific care requirements related to their condition. The Long-Term Care Home (LTCH) withheld their approval for admission.

A written refusal letter from a specified date, cited that the facility lacked the physical facilities, and the staff of the home lacked the nursing expertise necessary to meet the applicant's care requirements, and there were other circumstances as being a ground for withholding approval. The refusal letter did not explain how the physical facilities, the lack of nursing expertise or other circumstances per the regulation were not able to meet the applicant's care requirements for managing their specific needs as described above.

The Director of Care (DOC) was unable to provide sufficient information to substantiate specifically which type of home's physical facilities, staff's nursing expertise or other circumstances were lacking to meet the applicant's requirements. The home has a responsive behaviour program for managing responsive behaviours of residents. The home did not request additional information from Ontario Health atHome to confirm if the current home's conditions would suffice the applicant's specific needs.

When the home withheld the applicant's approval for admission without the appropriate grounds, they were not able to transition to the LTCH of their choice.

Sources: An applicant's application for admission to LTCH, including assessments, refusal letter, and interview with the DOC.

WRITTEN NOTIFICATION: Authorization for admission to a home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (9) (c)
Authorization for admission to a home

s. 51 (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,

(c) an explanation of how the supporting facts justify the decision to withhold approval

The licensee has failed to ensure that when the licensee withheld approval for admission, they gave the applicant a written notice setting out an explanation of how the supporting facts justify the decision to withhold approval.

Rationale and Summary

The MLTC received a complaint related to withholding an applicant's admission.

The applicant had specific care requirements related to their condition. The LTCH withheld their approval for admission.

A written refusal letter from a specified date cited the grounds of admission refusal were the current Korean residents of the home exhibited responsive behaviour towards non-Korean residents. Therefore, the home's reason for admission refusal of non-Koreans was a presumably unsafe environment for them.

The written letter failed to include an explanation of how the supporting facts justify the decision to withhold approval.

The DOC's explanation of how the supporting facts justified the decision to withhold approval were not based on the applicant's condition and requirements for care but on the potential trigger for responsive behaviours with the existing Korean residents.

When the home withheld the applicant's approval for admission without the appropriate grounds, the applicant was not able to transition to the LTCH of their choice.

Sources: An applicant's application for admission to LTCH, including assessments, refusal letter, and interview with the DOC.

WRITTEN NOTIFICATION: Authorization for admission to a home

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (9) (d)
Authorization for admission to a home

s. 51 (9) (d) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out

(d) contact information for the Director.

The licensee has failed to ensure that when the licensee withheld approval for admission, they gave the applicant a written notice setting out the contact information for the Director.

Rationale and Summary

A written refusal letter issued on a specified date, did not contain a contact for the Director.

The DOC acknowledged that the contact information for the Director was not included in the refusal letter.

Failure of the home to include the contact information of the Director in the written notice of withholding approval for admission disadvantaged the applicant to further communicate with the MLTC in regard to their admission in a LTC home.

Sources: An applicant's application for admission to LTCH, including assessments, refusal letter, and interview with the DOC.

WRITTEN NOTIFICATION: Falls prevention and management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when the resident had fallen, they were assessed after the fall as per the home's policy Falls Prevention and Management.

A resident sustained a fall on a specified date that resulted in injury. Interviews with staff indicated the resident was transferred back to their bed before staff had informed the registered nurse of the resident's fall.

As per the home's policy Falls Prevention and Management program, the resident who had fallen was not supposed to be moved prior to completion of a preliminary assessment by registered nursing staff.

Failure to ensure the resident was assessed immediately after the fall and before further movement could aggravate potential injuries.

Sources: Interview with home's staff and the DOC; observation of the resident; and record review of the home's policy Fall Prevention and Management program #16212555, dated February 2024.