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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 1, 2019	2019_739694_0002	026465-17	Complaint

Licensee/Titulaire de permis

The Regional Municipality of Peel
7120 Hurontario Street 6th Floor MISSISSAUGA ON L5W 1N4

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

Peel Manor
525 Main Street North BRAMPTON ON L6X 1N9

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

AMANDA COULTER (694)

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): Febuary 13, 27, and 28, 2019 as an off-site inspection.

Log #026465-17 related to illegal discharge.

During the course of the inspection, the inspector(s) spoke with the Director of Care.

The inspector also reviewed relevant resident clinical records.

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. 144. No licensee of a long-term care home shall discharge a resident from the long-term care home unless permitted or required to do so by this Regulation. O. Reg. 79/10, s. 144.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 was not discharged during an absence or as permitted or required to do so by the O. Reg. 79/10.

On a specific date in November 2017, a complaint was received regarding an illegal discharge of resident #001 from Peel Manor.

A record review showed that resident #001 was transferred to hospital and admitted on a specific date in October 2017.

On a specific date in October 2017, a care conference was attended by Peel Manor staff, hospital staff and the Substitute Decision Maker (SDM). There were no plans for discharge back to the facility discussed during the conference.Hospital staff stated the resident was stabilizing.

Two days after the care conference in October 2017, Director of Care (DOC) #100, staff #102 and the SDM met at the home. They advised the SDM they would not accept the resident back to the home.

In an interview with DOC #100, they stated the resident was still in the hospital at the time of discharge.

The licensee has failed to ensure that resident #001 was not discharged during an absence. [s. 144.]

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 a resident was not discharged during a psychiatric absence, 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 :

Before discharging resident #001, the licensee failed to: consider and try alternatives to discharge; make arrangements for the accommodation, care and secure environment required by the resident in consultation with the appropriate placement coordinator and other health service organizations; and keep the resident and their substitute decision maker informed, give them an opportunity to participate in the discharge planning and take their wishes into consideration.

On a specific date in November 2017, a complaint was received by the MOHTLC action line regarding an illegal discharge of resident #001 from Peel Manor.

A teleconference was held in October 2017, with resource and unit nurses at BCH and Peel Manor staff. Staff #102 documented the home communicated concerns regarding the facility not being able to care for resident #001 safely in an open environment. There were no plans for discharge discussed during the conference.

On a specific date in October 2017 a care conference was held at the hospital. The care conference was attended by staff of Peel Manor, hospital staff and the Substitute Decision Maker (SDM). There were no plans for discharge discussed during the conference. A hospital staff member stated the resident was stabilizing.

Two days after the care conference on a specific date in October 2017, Director of Care (DOC) #100, staff #102 and the SDM met at the home and staff advised the SDM they would not accept the resident back to the facility. In an interview with DOC #100, they stated the resident was still in the hospital at the time of the home's decision.

The SDM stated the resident remained in hospital for months awaiting placement at another long term care home that was located farther from their family and more expensive.

The license failed to consider and try alternatives to discharge; make arrangements for the accommodation, care and secure environment required by the resident in consultation with the appropriate placement coordinator and other health service organizations; and keep the resident and their substitute decision maker informed, give them an opportunity to participate in the discharge planning and take their wishes into consideration prior to discharging 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 that alternatives to discharge were considered and, where appropriate, tried; 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; 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, to be implemented voluntarily.

Issued on this 7th day of May, 2019

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

Original report signed by the inspector.