Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 1, 8, 9, 28, 2012	2012_102116_0023	Complaint

Licensee/Titulaire de permis

GEN HEALTH CARE GROUP LTD
~~PARAGON HEALTH CARE INC~~ 1046 BARRINGTON ST, 3rd Floor Halifax NS, B3H 2R1
~~c/o Deloitte & Touche Inc. 181 Bay Street, Brookfield Place, Suite 1400, TORONTO, ON, M5J-2V1~~

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

DOWNSVIEW LONG TERM CARE
~~CASA VERDE HEALTH CENTRE~~
3595 KEELE STREET, NORTH YORK, ON, M3J-1M7

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

SARAN DANIEL-DODD (116)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care, Resident Family Service Worker and a family member of a resident.

During the course of the inspection, the inspector(s) reviewed the health record of a resident.

The following Inspection Protocols were used during this inspection:

Hospitalization and Death

Medication

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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;
(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 an 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, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. The Licensee failed to do the following prior to discharging an identified resident from the home:

- ensure that alternatives to discharge were considered and, where appropriate, tried;
- in collaboration with the Community Care Access Centre and other health organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident;
- ensure that the resident, and the substitute decision-maker, if any, and any person either of them may direct was kept informed and given the opportunity to participate in the discharge planning and that her wishes were taken into consideration; and
- provide a written notice to the resident, her 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 to both the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge.

- An identified resident was transferred to the hospital for a psychiatric assessment and placed on psychiatric leave. The resident was discharged from the home prior to the completion of psychiatric leave.
- Interview held with members of the management team of the home confirmed that the home did not provide the resident or resident's substitute decision-maker with notice of discharge from the home.
- The Licensee informed placement services of the Community Care Access Centre (CCAC) of a bed vacancy for the resident as a result of being transferred to the hospital. No collaboration took place with the placement coordinator and other health service organizations.

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 shall,
(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 an 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, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2), to be implemented voluntarily.

Issued on this 5th day of September, 2012

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