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**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
**Direction de l'amélioration de la performance et de la conformité**

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486


**Public Copy/Copie du public**

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 1, 2014 | 2014_159178_0020 | T-1030-14/T-1074-14 | Complaint |

**Licensee/Titulaire de permis**

RYKKA CARE CENTRES LP
50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6

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

EATONVILLE CARE CENTRE
420 THE EAST MALL, ETOBICOKE, ON, M9B-3Z9

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

SUSAN LUI (178)

## 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): September 5, 8, 9, 2014.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Director of Care, Social Worker, registered staff, a resident's Physician, a resident's family.**

**During the course of the inspection, the inspector(s) reviewed resident records.**

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

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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 discharging a resident under subsection 145 (1) (the resident's requirements for care have changed and 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), alternative arrangements for the accommodation of the resident were made.

Staff interviews, family interview and record review confirm that when resident #1 was discharged from the home on an identified date, alternative arrangements for the resident's accommodation had not been made.
Record review and staff interviews confirm the following:
-Resident #1 was discharged from the home because the home determined that the resident's requirements for care had changed and as a result, the home could not provide a sufficiently secure environment to ensure the safety of persons who come into contact with the resident.
-The resident had also recently been assessed by the Community Care Access Centre (CCAC) and it was determined that the resident no longer met the eligibility requirements for long term care.
-The home's staff provided the resident with written notice, advising the resident that it had been determined that his/her requirements for care had changed and as a result, the long term care home (LTCH) could not provide a sufficiently secure environment to ensure the safety of persons who come into contact with the resident, therefore he/she would be discharged from the home. Assistance to arrange alternative accommodation was offered at this time.
-The home's staff made many attempts to assist the resident to arrange alternative accommodations; however those accommodations had not been successfully arranged at the time of the resident's discharge.
-On an identified date approximately one and one half months after providing the initial written notice, the home's staff provided the resident with a second written notice, stating that as the resident had been unwilling to cooperate with the home's staff in their efforts to locate alternative accommodation, and as the resident had failed to make reasonable efforts in this regard on his/her own, the resident would be discharged from the home on an identified date, in approximately one and one half months.
-The home discharged the resident from the long term care home three days later, after the resident was sent to hospital for assessment. Alternative arrangements for the resident's accommodation were not in place at the time of discharge. [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 under subsection 145 (1) (the resident's requirements for care have changed and 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), alternative arrangements for the accommodation of the resident are made, to be implemented voluntarily.***

---

**Issued on this 21st day of October, 2014**

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

Anam Sin (178)