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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 29, 30, Oct 4, 5, 13, 14, 2011	2011_077109_0028	Critical Incident

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

HAWTHORNE PLACE CARE CENTRE
2045 FINCH AVENUE WEST, NORTH YORK, ON, M3N-1M9

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

SUSAN SQUIRES (109)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Nurse Clinician, Social Worker, Residents, Registered Staff, Personal Support Workers, ADOC, CCAC Placement Coordinators, Family member

During the course of the inspection, the inspector(s) Walk through of the unit, reviewed health records for identified residents, reviewed policies, reviewed education records

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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 LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following subsections:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The Licensee has not provided training in the area of whistle-blowing protection afforded under section 26, to the staff prior to performing their responsibilities.
There are no education records to support training of staff in the area of whistle-blowing protection.
Inspector interviewed 4 staff members who stated that they have not received training in whistle-blowing protection and were unaware of what whistle-blowing protection entailed.
2. The Licensee has not provided training in the area of mandatory reporting under section 24 of the Act to the staff prior to performing their responsibilities.
There are no education records to support training of staff in the area of mandatory reporting.
Inspector interviewed 4 staff members who stated that they have not received training in mandatory reporting and were unaware of what mandatory reporting entailed.

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 all staff are provided with training in the area of whistle-blowing protections and mandatory reporting prior to performing their duties, 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 subsections:

s. 148. (1) Except in the case of a discharge due to a resident's death, every licensee of a long-term care home shall ensure that, before a resident is discharged, notice of the discharge is given to the resident, the resident's substitute decision-maker, if any, and to any other person either of them may direct,
(a) as far in advance of the discharge as possible; or
(b) if circumstances do not permit notice to be given before the discharge, as soon as possible after the discharge. O. Reg. 79/10, s. 148 (1).

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).

s. 148. (3) Before discharging a resident from the home under clause 145 (3) (a), (b) or (d), the licensee shall offer to,
(a) assist the resident in planning for discharge by identifying alternative accommodation, health service organizations and other resources in the community; and
(b) contact appropriate health service organizations and other resources in the community or refer the resident to such organizations and resources. O. Reg. 79/10, s. 148 (3).

Findings/Faits saillants :

A resident was discharged from the home by the Licensee.
The CCAC did not receive consultation from the Licensee prior to discharging a resident.
The resident's substitute decision-maker was not provided with any assistance from the Licensee to assist them to manage the resident's care prior to the discharge.[148(3)].

There were no alternatives to discharge considered and/or tried prior to discharging a resident. [148 (2) (a)]

There was no collaboration with the placement coordinator and other health service organizations, no alternative arrangements for the accommodation, care and secure environment required by the resident prior to discharging. [148 (2) (b)]

The licensee failed to provide a written notice to the resident's substitute decision-maker 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. [148 (2) (d)]
The resident's substitute decision-maker was not provided with notice of the discharge [148(1)]

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 all residents who are discharged from the home receive appropriate discharge planning as described in the legislation, to be implemented voluntarily.

Issued on this 17th day of October, 2011

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