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
Direction de l'amélioration de la performance et de la conformité

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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
Apr 26, 27, 30, May 1, 2, 8, 14, 15, 16, 28, 29, 30, 31, Jun 4, 2012	2012_077109_0017	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

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 Complaint inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Assistant Director of Care, Registered Nurse, Police Officers, Resident's, Placement Facilitator at CCAC, Supervisor at CCAC, Social Worker

During the course of the inspection, the inspector(s) Reviewed health record for identified residents

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Responsive Behaviours

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 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. A resident of Hawthorne Place Care Centre, was taken into police custody on April 19, 2012 for assaulting another resident in the home. He was released on his own recognizance and one of the conditions was that he refrain from going to the third floor of the home where the other resident lives. He returned to the home the same day.

The resident was taken into police custody on April 20, 2012 as a result of another incident outside of the home.

On April 23, 2012, the Licensee informed the Placement Coordinator for the Community Care Access Centre, that the identified resident was in police custody and the Licensee would not be letting the individual back in the home.

The resident was released on April 24, 2012 and then returned to the home at approximately 5:30 pm.

Upon the resident's return, the two Assistant Directors of Care, acting under the direction of the Licensee and senior management of the home, advised the resident that he/she was discharged from the home as of April 21, 2012.

The Licensee has admitted to discharging the identified resident on April 24, 2012 pursuant to s. 145(1) of O.Reg. 79/10.

The Licensee failed to do the following prior to April 21, 2012, the date the Licensee claims to have discharged the resident, and prior to April 24, 2012, the date the Licensee notified the residentthat he was discharged from the home:
- ensure that alternative 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 to his/her discharge on April 24, 2012;
- 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 his wishes were taken into consideration; and
- provide a written notice to the resident, his/her substitute decision-make, 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 Ivan Anthony's condition and requirements for care, that justify the licensee's decision to discharge him/her

2. The identified resident requires daily insulin injections to manage diabetes, daily medications to manage hypertension and other health conditions.

The identified resident was rendered homeless on April 24, 2012 after he/she was told that he/she was discharged from the home and was staying in a homeless shelter.

Additional Required Actions:

CO # - 901, 902 were served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:

1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

3. Resident monitoring and internal reporting protocols.

4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. An identified resident exhibited responsive behaviors of physical and verbal aggression, resistance to care, mood swings, poor judgment, hoarding, cursing, and other behaviors toward staff and other residents.

The Assistant Director of Care, and the Corporate Nurse stated that the Licensee has a screening tool which identifies whether a resident is a high, moderate or low risk based on the behaviors that are exhibited. The resident was not screened to aid in identification of the responsive behaviors. The Assistant Director of Care and the Corporate Nurse confirmed during an interview that there are currently no criteria to alert staff to conduct an assessment on a resident exhibiting aggressive and other behaviors such as the behaviours exhibited by the identified resident. [53(1)(1)]
2. There were no potential triggers identified even though progress notes indicate behaviors exhibited after specific interactions with staff or other residents.
The licensee has not referred him/her to specialized resources such as the Psychiatric Nurse who attends the home for residents under the age of 65 years [53(1)(4)].

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/ LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

CORRECTED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 r. 148.	WN #1	2012_077109_0017	109
O.Reg 79/10 r. 148. (2)	CO #902	2012_077109_0017	109

Issued on this 7th day of June, 2012

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