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

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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 25, 2018	2018_725522_0005	008132-18, 008367-18	Complaint

Licensee/Titulaire de permis

Rykka Care Centres LP
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

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

Berkshire Care Centre
350 Dougall Avenue WINDSOR ON N9A 4P4

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

JULIE LAMPMAN (522)

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): April 25, 26, 30, May 1, 2, 3, 4, 22, 24, July 5 and 6, 2018.

This off-site complaint inspection was related to the discharge of a resident.

The following complaint intakes were completed concurrently:
Log #008132-18/ IL-56569-LO
Log #008367-18/ IL-56641-LO

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, two Assistant Directors of Care, the Resident Assessment Instrument (RAI) Coordinator, the Admissions Coordinator/ Social Worker, the Business Manager, the Environmental Services Manager, the Director, Home and Community Care Erie St. Claire Local Health Integration Network (ESC LHIN), the Patient Services Manager ESC LHIN, Legal Services Manager Windsor Regional Hospital (WRH), the Health Records Clerk WRH, a Police Officer from Windsor Police Service (WPS), the Privacy Co-ordinator WPS, a lawyer, the Executive Director of Assisted Living Southwestern Ontario, Manager of Facilities, Housing & Environmental Services of Canadian Mental Health Association-Windsor Essex, Counsel from the Ministry of the Attorney General and a resident.

The inspector also reviewed a resident's clinical records, hospital admission and discharge records, police incident report, Client Record Information System records, and relevant policies and procedures.

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	Legendé 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. 145. When licensee may discharge

Specifically failed to comply with the following:

s. 145. (2) For the purposes of subsection (1), the licensee shall be informed by,
(a) in the case of a resident who is at the home, the Director of Nursing and Personal Care, the resident's physician or a registered nurse in the extended class attending the resident, after consultation with the interdisciplinary team providing the resident's care; or O. Reg. 79/10, s. 145 (2).
(b) in the case of a resident who is absent from the home, the resident's physician or a registered nurse in the extended class attending the resident. O. Reg. 79/10, s. 145 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was discharged if the licensee was informed by someone permitted to do so under subsection (2) that the resident's requirements for care had changed and that, as a result, the home could not provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who came into contact with the resident.

Ontario Regulation 79/10 s. 145(2)(b) states, "For the purposes of subsection (1), the licensee shall be informed by in the case of a resident who is absent from the home, the resident's physician or a registered nurse in the extended class attending the resident."

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) regarding a concern that Berkshire Care Centre (BCC) had refused to accept an identified resident back to the home after they were discharged from hospital.

An additional complaint was received by the MOHLTC regarding BCC's failure to meet the legislative requirements for the discharge of the identified resident.

A review of clinical records and interviews noted that the identified resident was admitted to hospital on a specific dated after an incident at the home. Once the resident was released from hospital the resident was forced to find alternative living arrangements as BCC would not accept the resident back into the home.

A review of the identified resident's progress notes in Point Click Care on the day the resident was admitted to hospital noted the home had stated the resident was not to be admitted back into the home.

A review of the Bed Vacancy Report from the Erie St. Clair Local Health Integration Network noted that BCC submitted a bed vacancy for the resident with a vacancy date stated as the day the resident was admitted to hospital. The report stated the resident was discharged to the community.

A review of the identified resident's most recent care plan noted the care plan was closed the day the resident was admitted to hospital, the reason for the closure of the care plan was noted as discharge. In a phone interview, the Resident Assessment Instrument (RAI) Coordinator confirmed they had closed the resident's care plan. The RAI Coordinator stated the only time they would close a resident's care plan was if the resident deceased or if they were discharged.

In a phone interview, the identified resident stated on a specific day a Manager at BCC told the resident they had to leave BCC and were not able to come back to BCC but did not give them a reason why. The resident was not given a discharge letter from BCC nor was the resident contacted by BBC while in the hospital.

In a phone interview, the Administrator and Director of Care stated that due to the resident's recent behaviour and additional factors it was recommended by their Head Office that BCC not take the resident back.

The licensee has failed to ensure that a resident was discharged if the licensee was informed by someone permitted to do so under subsection (2) that the resident's requirements for care had changed and that, as a result, the home could not provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who came into contact with the resident. [s. 145. (2) (b)]

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 a resident is discharged if the licensee is informed by someone permitted to do so under subsection (2) that the resident's requirements for care have changed and that, as a result, the home cannot provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who came into contact with the resident, 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 :

1. The licensee has failed to ensure that before discharging a resident under subsection 145 (1), the resident was kept informed and given an opportunity to participate in the discharge planning and that his or her wishes were taken into consideration; and

provided a written notice to the resident setting out a detailed explanation of the supporting facts, as they related both to the home and to the resident's condition and requirements for care, that justified the licensee's decision to discharge the resident.

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) regarding a concern that Berkshire Care Centre (BCC) had refused to accept an identified resident back to the home after they were discharged from hospital.

An additional complaint was received by the MOHLTC regarding BCC's failure to meet the legislative requirements for the discharge of the identified resident.

A review of clinical records and interviews noted that the identified resident was admitted to hospital on a specific dated after an incident at the home. Once the resident was released from hospital the resident was forced to find alternative living arrangements as BCC would not accept the resident back into the home.

A review of the Critical Incident System (CIS) report submitted by the home to the MOHLTC on a specific date, noted that the identified resident was no longer allowed to be at BCC. The CIS indicated the identified resident had moved out the home and would be placed in another facility with the support of the Local Health Integration Network (LHIN).

Review of Client Health Record Information System (CHRIS) notes from the Erie St. Clair LHIN regarding the identified resident noted the resident stated they had recently been discharged from BCC for an unknown reason and they had not been provided with an explanation, written or verbal notification, nor was resident involved in discharge planning.

In a phone interview, the identified resident stated on a specific day a Manager at BCC told the resident they had to leave BCC and were not able to come back to BCC but did not give them a reason why. The resident confirmed they had been discharged to alternative housing in the community and currently they were now living in another long-term care home. The resident was not given a letter from BCC nor was the resident contacted by BCC while in the hospital or community housing while discharge plans were being made.

In a phone interview, the Administrator and Director of Care stated that due to the resident's recent behaviour and additional factors it was recommended by their Head

Office that BCC not take the resident back.

When asked if this plan had been discussed with the identified resident, the Administrator stated they had not had any discussion with the resident.

The licensee has failed to ensure that before discharging a resident under subsection 145 (1), the resident was kept informed and given an opportunity to participate in the discharge planning and that his or her wishes were taken into consideration; and provided a written notice to the resident setting out a detailed explanation of the supporting facts, as they related both to the home and to the resident's condition and requirements for care, that justified the licensee's decision to discharge 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 under subsection 145 (1), the resident is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and provide a written notice to the resident 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, to be implemented voluntarily.

Issued on this 15th day of August, 2018

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

Original report signed by the inspector.