Ministry of Health and Long-Term Care

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Toronto Service Area Office

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Ministère de la Santé et des Soins de longue durée

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité
Bureau régional de services de Toronto

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Ontario

DEC 0 6 2010

Mr. Eric Harela
Administrator
Labdara Lithuanian Nursing Home
5 Resurrection Road
Etobicoke ON M9A 5G1

Dear Mr. Harela:

Please find enclosed the ***Inspection Report-Public Copy*** for an inspection conducted **September 28, 29, 2010** under the *Long-Term Care Homes Act, 2007* (LTCHA) for the purpose of ensuring compliance with requirements under the LTCHA.

This inspection report must be posted in the home, in a conspicuous and easily accessible location in accordance with the LTCHA, 2007, S.O. 2007, c.8, s.79 (1) and (2).

A copy of the ***Inspection Report-Public Copy*** must be made available without charge upon request. The report will also be on file with the Toronto Service Area Office, Performance Improvement and Compliance Branch.

Sincerely,

A. Marcello

for Susan Squires
LTC Homes Inspector

A. Marcello

for Susan Lui
LTC Homes Inspector

Ontario

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

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

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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
28/09/10 and 29/09/10	2010_109_2860_28Sep142233	Complaint T-1348

Licensee/Titulaire

Labdara Foundation, 5 Resurrection Road, Toronto ON, M9A 5G1

Labdara Lithuanian Nursing Home, 5 Resurrection Road, Toronto ON, M9A 5G1

Susan Squires, 109
Susan Lui, 199

Inspection Summary/Sommaire d'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 and the Director of Care.

During the course of the inspection, the inspector(s): reviewed the medical record and business file of one resident.

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

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
1 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with O. Reg. 79/10, s. 145 (1). A licensee of a long-term care home may discharge a resident 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 come into contact with the resident.

Findings:

1) A resident whose care requirements had not changed was discharged from the home.

Inspector ID #:	109, 199

WN #2: The Licensee has failed to comply with O. Reg. 79/10, s. 148 (1).

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.

Findings:

1) There was no notice given to the POA of the discharge until the day of the discharge.

Inspector ID #:	109, 199

WN #3: The Licensee has failed to comply with O. Reg. 79/10, s. 148 (2).

(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.

Findings:

1) There were no alternatives to discharge considered or tried prior to a residents discharge to hospital.

2) There was no collaboration with a placement coordinator or other health service organizations prior to the discharge of a resident to the hospital.

3) There is no evidence to support that the POA was kept informed and given the opportunity to participate in discharge planning prior to discharge.

4) Written notice to the substitute decision-maker outlining the reasons for discharge was provided after the discharge order was written.

Inspector ID #:	109, 199

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 with the requirement that before discharging a resident under subsection 145 (1), the licensee shall:

- ensure alternatives to discharge have been considered and tried where appropriate,
- collaborate with appropriate placement co-ordinator and other health service organizations to make alternative arrangements for accommodation, care and secure environment required by the resident,
- ensure the resident and substitute decision-maker are kept informed and given an opportunity to participate in the discharge planning,
- provide a written notice to the resident and 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 the resident.

Written plan of correction is to be implemented voluntarily.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. (109) (199)
Title: Date:	Date of Report: (if different from date(s) of inspection).