



**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
prévus le Loi de 2007 les
foyers de soins de longue**

Health System Accountability and Performance
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Division de la responsabilisation et de la
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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
Nov 23, 24, 28, 29, Dec 6, 2011	2011_034117_0036	Complaint

Licensee/Titulaire de permis

SEASONS RETIREMENT COMMUNITIES (MADONNA LTC) GP
100 Milverton Drive, Suite 300, MISSISSAUGA, ON, L5R-4H1

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

MADONNA LONG-TERM CARE RESIDENCE
1541 St. Joseph's Boulevard, Orleans, ON, K1C-1S9

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

LYNE DUCHESNE (117)

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 the home's Administrator, Chief Medical Officer, the Director of Care (DOC), the home's Social Worker (SW), a Registered Practical Nurse (RPN), to three Personal Support Workers (PSW), the receptionist, to several residents, to a Champlain Community Care Access Center Case Manager (CCAC CM), to a Champlain Community Care Access Center Program Manager and to a Public Guardian and Trustee Agent (PGT).

During the course of the inspection, the inspector(s) reviewed an identified resident's health care record.

The following Inspection Protocols were used during this inspection:

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES



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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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. The identified resident was admitted to the Madonna Nursing Home several years ago. At that time, the resident was deemed incapable of making placement decisions.

In August 2011, the resident is deemed capable of making his/her own care decisions and is aware of the consequences of his/her actions as per an assessment done at an Ottawa hospital.

The resident's attending physician/ Chief Medical Officer and Madonna's multidisciplinary team confirm that the resident was capable of making his/her own care decisions, knew the consequences of his/her actions and had expressed multiple times his/her wish not to be at Madonna Nursing Home. Since August 2011, the Madonna's SW had been exploring alternative housing options for and with the resident.

Madonna's multidisciplinary team confirms that the PGT office was not involved with the resident regarding care and treatment decisions since the resident's admission to Madonna. However the PGT has been overseeing the resident's finances since his/her admission to long-term care (LTC). Although the home had been in contact with PGT for various financial questions, PGT were not consulted or involved in alternative housing options being discussed with the resident. This was confirmed via telephone interview with the PGT office on November 23 2011.

Madonna's multidisciplinary team confirms that the Champlain CCAC still manages resident's waitlist status for admission to another LTC home but were not consulted or involved in alternative housing options being discussed with the resident. This is confirmed with Champlain CCAC Case Manager on November 28 2011.

On an identified date in October 2011, since early morning the resident had been having multiple responsive behaviours towards other residents and staff members. At mid-morning, the resident was assessed at the home by an attending physician who requested that the resident be immediately assessed in hospital as the resident was deemed to be a risk to himself / herself and others at that time.

At the hospital emergency department (ER), the resident was assessed by a physician who deemed the resident capable and aware of his / her actions. The resident was not deemed to require hospitalization and plans were being made to return the resident to Madonna.

Madonna's Chief Medical Officer was notified of the resident's anticipated return to Madonna. An internal multidisciplinary meeting was held at Madonna. It was determined that the resident still posed a risk to staff and residents and was subsequently discharged from the home under O.Reg 79/10 section 145 (1 and 2) as per interview with the Chief Medical Officer on November 28 2011. SW progress note dated October 27 2011 and physician progress note dated October 31 2011 in the resident's health care record document Madonna Nursing Home's decision to discharge the resident.

Madonna's Chief Medical Officer spoke with the ER RN in the late afternoon of the identified date in October 2011, to confirm that the resident was discharged from Madonna Nursing Home. The ER RN is said to have advised the resident of his/her discharge from Madonna. The resident in return expressed his/her wish to not return to the Madonna Nursing Home. The ER RN contacted the ER SW to make alternative housing arrangements for the resident, as per interview with Madonna's Chief Medical Officer on November 28 2011.

As per section 148 (b,c, and d), the Licensee failed to collaborate with appropriate placement coordinator and other health service organizations, make alternative arrangements for the accommodation and care required by the resident on an identified date in October 2011.

Prior to discharging the resident on an identified date in October 2011, the resident and PGT for finance were not given an opportunity to participate in the discharge planning process.

The home did not provide a written notice to the resident and to the PGT for finance, setting out 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 home's decision to discharge the resident on an identified date in October 2011.



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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, the licensee must work in collaboration with the resident, the substitute decision maker if any, the placement coordinator and any other health service organization, to make alternative arrangements for accommodation and care and to give a written notice to the resident setting out detailed explanation of supporting facts that justify the decision to discharge the resident, to be implemented voluntarily.

Issued on this 7th day of December, 2011

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

Lynne Jackson #117.