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 prévue le Loi de 2007 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

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 05, 2018;	2018_601532_0013 (A1) (Appeal\Dir#: DR# 095)	015673-18	Complaint

Licensee/Titulaire de permis

Collingwood Nursing Home Limited
250 Campbell Street COLLINGWOOD ON L9Y 4J9

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

Collingwood Nursing Home
250 Campbell Street COLLINGWOOD ON L9Y 4J9

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

Amended by Wendy Lewis (Director) - (A1)(Appeal\Dir#: DR# 095)

Amended Inspection Summary/Résumé de l'inspection modifié

NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector's order(s): CO#001.
The Director's review was completed on October 05, 2018.
Order(s) was/were rescinded and substituted with a Director Order to reflect the Director's review DR# 095.
A copy of the Director Order is attached.

Issued on this 5 day of October 2018 (A1)(Appeal\Dir#: DR# 095)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

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

Amended by Wendy Lewis (Director) - (A1)(Appeal/Dir# DR# 095)

Amended Inspection Summary/Résumé de l’inspection modifié

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 4, 5,6, 10, 11,12, 2018.

related to illegal discharge.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, associate Director of Care, Nurse Practitioner, Manager for Convalescent Care, Local Health Integration Network (LHIN) Director, LHIN Placement Coordinators, Baycrest Social Worker, Registered Nurses, Registered Practical Nurses, Personal Support Workers, and residents.

Inspector also toured the resident home areas, observed resident care provision; resident/staff interaction, reviewed relevant resident’s clinical records, relevant policies and procedures, as well as notes pertaining to the inspection.

The following Inspection Protocols were used during this inspection:

Admission and Discharge

During the course of the original inspection, Non-Compliances were issued.

2 WN(s)
1 VPC(s)
1 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. 138. Absences

Specifically failed to comply with the following:

s. 138. (1) If the requirements set out in subsection (2) are met, but subject to subsection (3), a licensee of a long-term care home shall ensure that when a long-stay resident of the home returns from a medical absence, psychiatric absence, casual absence, or vacation absence, the resident receives the same class of accommodation, the same room, and the same bed in the room, that the resident had before the absence. O. Reg. 79/10, s. 138 (1).

Findings/Faits saillants :

1. s.138. (1) If the requirements set out in subsection (2) are met, but subject to subsection (3), a licensee of a long-term care home shall ensure that when a long-stay resident of the home returns from a medical absence, psychiatric absence, casual absence, or vacation absence, the resident receives the same class of accommodation, the same room, and the same bed in the room, that the resident had before the absence. O. Reg. 79/10, s. 138 (1).

A verbal complaint was received regarding an illegal discharge at Collingwood Nursing Home. The complaint was concerning an identified resident who was on a leave of absence. There was a discharge meeting scheduled and the resident was due to return home on an identified date. The Administrator at the home discharged the identified resident while they were temporarily away from the home receiving care and without having a discussion with the physician at the hospital.

Record review showed that there was an agreement to accept the identified resident back into Collingwood Nursing Home upon discharge from the leave of absence.

The Nurse Practitioner (NP) said that they requested for the Ontario Telemedicine Network (OTN) as the home's management team wanted to see the identified resident as well as have a face to face meeting, however, the OTN was denied and the documents i.e. care plan and notes requested by the NP were not received by the home.

Social Worker (SW) at the hospital indicated that they spoke with the NP at the home to organize a teleconference and to send all documents to review prior to the meeting. The SW said that the home discharged the resident even prior to the

teleconference and prior to the leave of absence was done. The SW indicated that the resident was appropriate for returning back to the home.

In an interview Director for North Simcoe Muskoka Local Health Integration Network stated that the DOC had left a voice mail for the LHIN Placement Coordinator stating that identified resident was discharged from the home. The Placement Coordinator called back and informed the home that the resident had specified days and their absence had not expired. The DOC informed the LHIN Placement Coordinator that the discharge was at their initiative and they were refusing to have the resident return to the home.

The DOC stated that the resident was discharged before the leave of absence was up and before having the discharge meeting because the identified resident was due to return before the long weekend and the home had no communication with the hospital. The DOC said that since both the Administrator and the DOC were present in the home and knew that the resident was in a safe place; they decided to make arrangements for discharge so they did not leave the discharge for staff on the long weekend. The Administrator said that they took full responsibility for discharging the identified resident from the home.

The licensee failed to ensure that when the identified resident was due to return from an absence, the resident received the same class of accommodation, the same room, and the same bed in the room, that the resident had in Collingwood Nursing Home before the absence. O. Reg. 79/10, s. 138 (1). [s. 138. (1)]

Additional Required Actions:

(A1)(Appeal/Dir# DR# 095)
The following order(s) have been rescinded:CO# 001

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. Before discharging a resident under subsection 145 (1) the licensee failed to ensure that alternatives to discharge were considered and, where appropriate, tried; 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; ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct was kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration.

A verbal complaint was received regarding an illegal discharge at Collingwood Nursing Home. The complaint was concerning an identified resident who was on a leave of absence. There was a discharge meeting scheduled and the resident was due to return home on an identified date. The Administrator at the home discharged the identified resident while they were temporarily away from the home

receiving care and without having a discussion with the physician at the hospital.

Record review showed that there was an agreement to accept the identified resident back into Collingwood Nursing Home upon discharge from the leave of absence.

The Nurse Practitioner (NP) said that they requested for the Ontario Telemedicine Network (OTN) as the home's management team wanted to see the identified resident as well as have a face to face meeting, however, the OTN was denied and the documents i.e. care plan and notes requested by the NP were not received by the home.

Social Worker (SW) at the hospital indicated that they spoke with the NP at the home to organize a teleconference and to send all documents to review prior to the meeting. The SW said that the home discharged the resident even prior to the teleconference and prior to the leave of absence was done. The SW indicated that the resident was appropriate for returning back to the home.

In an interview the SDM indicated that they received the letter from the home and they did not have an opportunity to participate in the discharge planning and did not have any prior knowledge that the home was going to discharge the resident. They were expecting the resident to return back to Collingwood Nursing Home.

In an interview Director for North Simcoe Muskoka Local Health Integration Network stated that the DOC had left a voice mail for the LHIN Placement Coordinator stating that identified resident was discharged from the home, there was no collaboration prior to the discharge.

The DOC stated that the resident was discharged before the leave of absence was up and before having the discharge meeting because the identified resident was due to return before the long weekend and the hospital had no communication with the home. The DOC said that since both the Administrator and the DOC were present in the home and knew that the resident was in a safe place; they decided to make arrangements for discharge so they did not leave the discharge for staff on the long weekend.

The Administrator said that they took full responsibility for discharging the identified resident from the home. The DOC and the Administrator acknowledged that they did not have a formal meeting with the LHIN coordinator or had an opportunity to

participate in the discharge planning or make alternative arrangements for the accommodation.

The licensee failed to ensure that before discharging the identified resident alternatives to discharge were considered and, where appropriate, tried; 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; ensure that the resident and the resident's substitute decision-maker, if any, and any person either of them may direct was kept informed and given an opportunity to participate in the discharge planning and that his or her wishes were taken into consideration. O. Reg. 79/10, s. 138 (1). [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 that alternatives to discharge were considered and, where appropriate, tried; 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; 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, to be implemented voluntarily.

Issued on this 5 day of October 2018 (A1)(Appeal/Dir# DR# 095)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by Wendy Lewis (Director) - (A1) (Appeal/Dir# DR# 095)
Inspection No. / No de l'inspection :	2018_601532_0013 (A1)(Appeal/Dir# DR# 095)
Appeal/Dir# / Appel/Dir#:	DR# 095 (A1)
Log No. / No de registre :	015673-18 (A1)(Appeal/Dir# DR# 095)
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 05, 2018;(A1)(Appeal/Dir# DR# 095)
Licensee / Titulaire de permis :	Collingwood Nursing Home Limited 250 Campbell Street, COLLINGWOOD, ON, L9Y-4J9
LTC Home / Foyer de SLD :	Collingwood Nursing Home 250 Campbell Street, COLLINGWOOD, ON, L9Y-4J9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Peter Zober

To Collingwood Nursing Home Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

(A1)(Appeal/Dir# DR# 095)
The following Order has been rescinded:

Order # / Ordre no : 001 **Order Type / Genre d’ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 138. (1) If the requirements set out in subsection (2) are met, but subject to subsection (3), a licensee of a long-term care home shall ensure that when a long-stay resident of the home returns from a medical absence, psychiatric absence, casual absence, or vacation absence, the resident receives the same class of accommodation, the same room, and the same bed in the room, that the resident had before the absence. O. Reg. 79/10, s. 138 (1).

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 5 day of October 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by Wendy Lewis (Director) - (A1) (Appeal/Dir# DR# 095)

Service Area Office / Bureau régional de services : Central West