Ministry of Health and Long-Term Care
Long-Term Care Homes Division
Long-Term Care Inspections Branch

Ministère de la Santé et des Soins de longue durée
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	☐ **Licensee Copy/Copie du Titulaire** ✕ **Public Copy/Copie Public**
Name of Director:	Wendy Lewis
Order Type:	☐ Amend or Impose Conditions on Licence Order, section 104 ☐ Renovation of Municipal Home Order, section 135 ✕ Compliance Order, section 153 ☐ Work and Activity Order, section 154 ☐ Return of Funding Order, section 155 ☐ Mandatory Management Order, section 156 ☐ Revocation of License Order, section 157 ☐ Interim Manager Order, section 157
Intake Log # of original inspection (if applicable):	015673-18
Original Inspection #:	2018_601532_0013
Licensee:	Collingwood Nursing Home Limited 250 Campbell Street, COLLINGWOOD, ON, L9Y-4J9
LTC Home:	Collingwood Nursing Home 250 Campbell Street, COLLINGWOOD, ON, L9Y-4J9
Name of Administrator:	Peter Zober

Background:

Ministry of Health and Long-Term Care (MOHLTC) Inspector #532 conducted an inspection at Collingwood Nursing Home (LTC home) on the following dates: July 4, 5, 6, 10, 11, 12, 2018. (2018_601532_0013). The inspection was a Complaint Inspection at which time one intake log (#015673-18) was inspected.

During the inspection, the Inspector determined that the Licensee, Collingwood Nursing Home Limited (Collingwood Nursing Home or the Licensee), failed to comply with certain requirements (as identified below) of the Long-Term Care Homes Act, 2007 (LTCHA) and Ontario Regulation 79/10 (Regulation) under the LTCHA, and issued Compliance Order #001, which stated the following:

The licensee must be compliant with s.138 (1) of the LTCHA.
Specifically, the licensee must ensure:
a) should resident #001 or any other resident of the home wish to return from a medical absence, psychiatric absence, casual absence, or vacation absence, the resident is offered the same class of accommodation, the same room, and the same bed in the room, that the resident had before the absence.
b) the management team and the Medical Director at the home all receive training on Ontario Regulation 79/10 as it relates to medical, psychiatric, casual, and vacation absences, and when the licensee may discharge a resident.
This order must be complied with by: October 12, 2018
Following the conclusion of a Director's review under section 163 of the LTCHA, the above order has been altered and substituted with the Director's Order below.

Order #:	001

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

Pursuant To:

O.Reg 79/10, s. 144. No licensee of a long-term care home shall discharge a resident from the long-term care home unless permitted or required to do so by this Regulation. O. Reg. 79/10, s. 144.

Order:

1. The discharge of Resident #001 on June 21, 2018 was not valid because it violated section 144 of the Regulation. As such, the Licensee must accept Resident #001 back to Collingwood Nursing Home should the resident wish to return.
2. The Licensee shall ensure that no resident is discharged from the long-term care home unless they are permitted or required to do so by the Regulation.
3. The Licensee shall ensure that if Resident #001 or any other resident is discharged from Collingwood Nursing Home pursuant to subsection 145(1) of the Regulation, that the resident is discharged in accordance with subsection 145(1), including the requirement of being informed by the appropriate person permitted to do so as described in subsection 145(2) of the Regulation.
4. In the event that Resident #001 is transferred from the hospital back to Collingwood Nursing Home, the Licensee shall put in place measures to ensure that Resident #001 and all residents and staff are kept safe.

Grounds:

The Licensee has failed to ensure that Resident #001 was discharged as permitted or required to do so by the Regulation.
An inspection was conducted related to a complaint received by MOHLTC on June 29, 2018 indicating that Resident #001 was illegally discharged from Collingwood Nursing Home.
Resident #001 was admitted to Baycrest Centre on May 1, 2018 for psychiatric evaluation and the treatment of escalating responsive behaviours.
A review of Resident #001's records identified that a document titled "Centralized Intake and Referral Application to Specialty Hospitals" was signed by the resident's substitute decision-maker. In the same document, there was a "Take Back Agreement" clause that was signed by the Director of Care at Collingwood Nursing Home indicating that Resident #001 would be accepted back into the LTC home upon discharge from Baycrest Centre's Behavioural Neurology unit.
On June 14, 2018, the Social Worker from Baycrest Centre notified the Nurse Practitioner (NP) at the LTC home that they were planning to discharge the resident back to the LTC home on June 28, 2018 and wanted to set up a teleconference with the LTC home on June 26, 2018 to facilitate the resident's return back to the LTC home. The Nurse Practitioner requested care plan documents and medications for Resident #001. The Social Worker told the Inspector that the documents were faxed to the LTC home and that they had a fax confirmation sheet to prove that the fax was sent.
On July 5, 2018, the Social Worker told the Inspector that Resident #001 was admitted to the Behavioural Neurology Program at Baycrest Centre, which was a 20 bed short-term inpatient unit that focused on the assessment and treatment of adults with a diagnosis of neuro-cognitive disease, specifically dementia. They further explained that Resident #001 was ready to be discharged back to the LTC home as they were not exhibiting responsive behaviours. They said that the LTC home discharged the resident prior to the teleconference and prior to the end of the 60-day psychiatric leave of the resident.
On July 5, 2018, during an interview with the Nurse Practitioner, they indicated that they requested documents from Baycrest Centre, which were not received by the LTC home. The stated that they were willing to drive out to Baycrest Centre to see the resident; however, it was not requested by the Administrator or the DOC. The NP further stated that the Director for Baycrest Centre, on June 28, 2018, left a voicemail after the discharge but they did not return the call because the Resident was no longer in the LTC home. They stated that

they were not made aware of the discharge when it occurred, as the management team did not mention this to them and it was a surprise.

On July 6, 2018, during an interview with the Director for North Simcoe Muskoka Local Health Integration Network (LHIN), they told the Inspector that on June 21, 2018, the DOC left a voicemail for the LHIN Placement Coordinator stating that Resident #001 was discharged from the LTC home. The Placement Coordinator called back the same day and informed the LTC home that the resident had 60 days for their psychiatric absence, which had not expired. During that conversation, the DOC said that the discharge was at their initiative and they were refusing to have the resident return to the LTC home. The LHIN Placement Coordinator again informed the DOC that Resident #001 was allowed 60 days for a psychiatric absence which had not expired.
On July 12, 2018, during an interview with the Inspector, the ADOC #109 stated that they did not call Baycrest Centre to request any information. They said that the Nurse Practitioner was the point of contact for Baycrest. The ADOC indicated that the NP had informed them that Baycrest Centre was not sending the requested information and had denied a request from the home for a meeting via the Ontario Telemedicine Network. (OTN)
On July 5, 2018, the DOC told the Inspector that the resident was discharged before the 60-day psychiatric absence was up and before having a teleconference meeting with Baycrest Centre because the resident was due to return before the long weekend and the LTC home had no communication with Baycrest. It was asked if the DOC made any attempt to communicate with Baycrest Centre and they said that all the communication was between the NP and Baycrest and not the DOC. The DOC said that since both the Administrator and the DOC were present in the LTC home and knew that the resident was in a safe place at Baycrest Centre, they decided to make the arrangements for discharge of the resident.
On July 5, 2018, the Administrator told the Inspector that they took full responsibility for discharging the resident from the LTC home. They said that they took the resident's aggression history into account and were concerned for the resident's safety and the safety of others.
During an interview with the Inspector, the SDM indicated that they were provided a letter from the LTC home that indicated that Resident #001 had been discharged. The SDM did not recall any prior meetings with the LTC home to discuss alternatives to discharge.

As the resident was still on a valid psychiatric absence at the time of discharge and no information established that the resident's care requirements had significantly changed, the Licensee was not required or permitted to discharge Resident #001 from the LTC home.

Based on the information and evidence collected from the inspection, the Licensee was not informed by a physician or a registered nurse in the extended class attending the resident at Baycrest Centre, that the resident’s requirements for care had changed and that, as a result, the home would not be able to provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come into contact with the resident. Rather, the Social Worker from Baycrest indicated that the Resident had stabilized and was no longer exhibiting responsive behaviours, and as such, could be repatriated to the LTC home.

The application of factors taken into account under section 299(1) of the Regulation requires a Compliance Order to be issued. The severity of not allowing the resident to return to the LTC home as planned is assessed as a level 2, as minimum harm or potential for actual harm to the resident, as it relates to the resident being away from the LTC home and not being able to see their spouse often due to the significant travel required. The scope is assessed as a level 1 as it was isolated to Resident #001. The home does not have a history of related non-compliance.

This order must be complied with by:	November 16, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Long-Term Care Inspections Branch
1075 Bay St., 11th Floor, Suite 1100
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.

Issued on this 5th day of October, 2018	
Signature of Director:	
Name of Director:	Wendy Lewis