Ontario

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

Ministère de longue durée
Inspection de soins de longue durée
Division des foyers de soins de longue durée

Order(s) of the Director

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

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Name of Director:	Brad Robinson
Order Type:	X Compliance Order, section 153 ☐ Work and Activity Order, section 154 ☐ Amend or Impose Conditions on Licence Order, section 104 ☐ Renovation of Municipal Home Order, section 135 ☐ Return of Funding Order, section 155 ☐ Mandatory Management Order, section 156 ☐ Revocation of Licence Order, section 157 ☐ Interim Manager Order, section 157
Licensee:	Wikwemikong Nursing Home Limited
LTC Home:	Wikwemikong Nursing Home
Name of Administrator:	Cheryl Osawabine-Peltier

Background:
Wikwemikong Nursing Home is a licensed long-term care home on Manitoulin Island with 59 beds. The licensee of the home is Wikwemikong Nursing Home Limited. On August 18, 2021 as part of inspection #2021_805638_0018 a Director Referral was made in accordance with s. 152, paragraph 4 of the *Long-Term Care Homes Act, 2007* (LTCHA). The Director Referral was made after the inspector reissued a second consecutive compliance order under O. Reg. 79/10 s. 145. This referral was specifically related to subsection 145(1).

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Order:	#001

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

Pursuant to:

Subsection 145(1) (When licensee may discharge) of O. Reg 79/10 under the *Long-Term Care Homes Act, 2007*, states:

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. O. Reg. 79/10, s. 145 (1).

Order:

The licensee must be complaint with s. 145 (1) of O. Reg. 79/10.

Specifically, the licensee shall:

1. (a) Return resident #001, if the resident or SDM so chooses, into the same class of accommodation, the same room, and the same bed in the room that the resident had prior to discharge.

(b) Should the resident's bed and room (at the time of discharge) not be available, return the resident into a similar class of accommodation.

(c) Should a similar class of accommodation not be available, return resident #001 to a bed

using the temporary emergency licence. At the next available opportunity, resident #001 shall be moved to their original class of accommodation.

2. Collaborate with the health service organization where resident #001 currently resides to ensure that care and services as per the resident's assessed needs are provided upon their re-admission.

3. Implement the revised compliance plan to ensure that interventions are in place to respond to any responsive behaviours.

Grounds:

September 2020 – January 2021

A complaint was submitted to the Director in October 2020, outlining that resident #001 was transferred to the hospital from Wikwemikong Nursing Home on a day in September 2020, and then discharged from Wikwemikong Nursing Home the following day.

A complaint inspection # 2020_669642_0021 was conducted on November 16-20, 23-27, 2020. The inspection report noted that during an interview with the resident's Physician, they stated that they did not discharge this resident from the home and that they were not part of the discharge planning process for the resident. The inspection report also noted that the Director of Care at that time had not engaged in any discharge planning and had not followed the home's discharge policy. During the inspection the Inspector found that the licensee, Wikwemikong Nursing Home Limited, failed to comply with section 148(2) of O. Reg. 79/10 under the LTCHA. Pursuant to s. 153 (1)(a) of the LTCHA, the Inspector issued an order, Compliance Order #004 (CO), in relation to s. 148 (2) of O. Reg 79/10 in which the licensee was ordered to ensure that the licensee comply with the requirements in s.148 of O. Reg 79/10 before discharging a resident. The CO was served on the licensee on January 6, 2021 and the licensee had until March 5, 2021 to comply with CO #004.

February 2021 – June 2021

Subsequent complaints were received by the Ministry of Long-Term Care in February 2021, related to the same concerns as resident #001 remained in an acute care facility and had not been repatriated back to the home.

On March 16, 17, 22, 23, 25, 29, April 14, 15, 21, and May 3, 4, 2021, a second complaint inspection was conducted in relation to the two complaints received. During the inspection, the Inspector found that the licensee failed to comply with section 145(1) of O. Reg 79/10. The inspection report noted that the Inspector reviewed health care documents, including

assessments, from the acute care facility where the resident was living. They concluded that the resident had not exhibited any responsive behaviours that would prevent them from returning to the LTC home. The Inspector also spoke with the Home and Community Care Support Services discharge planner from the facility where the resident was residing and the discharge planner indicated that the resident wished to return to the LTC home and that the attending physician assessed the resident not to require enhanced supports. Pursuant to s.153 (1)(a) of the LTCHA, the Inspector issued an order (CO #001), during inspection #2021_638542_0006 in relation to the improper discharge of resident #001.The licensee was ordered to have resident #001 returned back to the home. CO # 001 was served on the licensee on May 21, 2021, with a compliance due date of May 28, 2021.

On May 21, 2021, the licensee submitted a request for the Director to review CO #001 from inspection #2021_638542_0006. A Director Review was conducted, and the Inspector's Order was confirmed by the Director on June 21, 2021. The Director found that based on their review, the documents and interviews confirm that the licensee discharged the resident in a manner that was not in accordance with s. 145(1) of O. Reg 79/10.

July 2021 – August 2021

On July 9, 2021, the licensee submitted a revised compliance plan to the MLTC outlining the strategies that would be put in place for the safe repatriation of the resident back to Wikwemikong Nursing Home. As the licensee did not have a vacant bed at that time, a temporary emergency license was issued by MLTC on August 3, 2021, to facilitate the resident's transfer back to the home.

When the resident had still not been transferred back to the home, a Follow-Up (FU) inspection was arranged. An offsite FU inspection, #2021_805638_0018, was conducted on August 16 and 17, 2021, in relation to Compliance Order #001 from inspection 2021_638542_0006.

The Inspector's findings during the FU inspection found continued non-compliance with s. 145 (1) of O. Reg 79/10. The Inspector issued 1 Written Notification which was referred to the Director for further action, and 1 Compliance Order. These were in relation to the licensee's failure to comply with s. 145(1) of O. Reg 79/10.

The FU Inspection (2021_805638_0018) report was served on the licensee on August 18, 2021 with a compliance due date of August 20, 2021.

The Follow-Up Inspection referenced CO #001 from inspection #2021_638542_0006. The Inspector re-issued the Compliance Order taking into account that there was actual harm to the resident as they were residing elsewhere, impacting their quality of life.

CO #001 from the FU inspection outlined the following:

The licensee must be compliant with s. 145 (1) of Ontario Regulations 79/10.

Specifically, the licensee shall:

1 (a) Return resident #001, if the resident or SDM so chooses, into the same class of accommodation, the same room, and the same bed in the room that the resident had prior to discharge.

(b) Should the resident's bed and room (at the time of discharge) not be available, return the resident into a similar class of accommodation.

(c) Should a similar class of accommodation not be available, return resident #001 to a bed using the temporary emergency license. At the next available opportunity, resident #001 shall be moved to their original class of accommodation.

2) Collaborate with the current health service organization where resident #001 currently resides to ensure that care and services as per the resident's assessed needs are provided upon their re-admission.

3) Implement the revised compliance plan to ensure that interventions are in place to respond to any responsive behaviours.

This second compliance order was issued based on evidence to support ongoing noncompliance with s. 145(1) O. Reg 79/10, as the licensee failed to ensure that prior to discharging a resident from the long term care home, 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. Corrective action by the licensee was not taken as necessary; and a written record was not kept of everything as required under the Regulation.

Noncompliance from FU inspection #2021_805638_0018 was supported by the following:

- Resident #001 had not been repatriated back to Wikwemikong Nursing Home. They remained in an acute care facility, where they had been living for 11 months
- The resident expressed their desire to return to their home at Wikwemikong Nursing Home.
- The Administrator and Director of Care (DOC) indicated that they did not intend to accept the resident back because of the resident's responsive behaviours and the home's inability

to manage them.

- Regarding bed availability, the Administrator stated that they currently had two available beds, one of which was an emergency licence specifically designated for resident #001.

While the attending physician for Wikwemikong Nursing Home felt the resident was not safe for the home, the Administrator acknowledged that the physician from Oak Lodge, the responsive behaviour assessment unit where the resident had previously been assessed, deemed that the resident did not meet their criteria for admission to the behaviour assessment unit and should be sent back to the Long-Term Care Home.

Currently:
There have been two separate compliance orders issued by different inspectors requiring the licensee to accept the return of the resident to the long-term care home. One order was issued in May 2021 and another in August 2021. However, as of September 8, 2021, the resident in question remains in an acute care facility and there have been no attempts by Wikwemikong Nursing Home to repatriate the resident as outlined in outstanding compliance order #001 from inspection #2021_805638_0018.

On August 26, 2021, the Director met with the home's management together with representatives from the facility where the resident was living and Home and Community Care to discuss next steps in relation to the resident's discharge. At that time, it was decided that the home would look into the possibility of discharging the resident back to their family home on the reserve with community supports. Following a meeting of health system partners on August 30, 2021, the Director was advised that the physician from the acute care facility where the resident was living, as well as Home and Community Care, did not feel that returning the resident to their community home was a safe plan given the care needs of the resident. On August 30, 2021, the home was again advised by the Director that the existing compliance order remained valid and they were expected to comply immediately.

On September 7, 2021, it was confirmed that the resident remained in the acute care facility and there had been no attempts by the home to repatriate the resident.

Relying on the findings and evidence gathered in the identified inspections and the update provided above, the Director is issuing a compliance order pursuant to s.153(1) of the LTCHA. The Licensee's continued non-compliance with these requirements has resulted in the resident remaining displaced from their home, in an acute care facility, for more than 11 months. This Order is required to have the Licensee achieve compliance with the LTCHA particularly with respect to discharge of a resident and to ensure that the resident is returned back to their home safely.

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The decision to issue this Director's Order is based on the scope and severity of non-compliance, and the LTC home's compliance history over the past 36 months. The scope is identified as isolated, impacting one resident that was discharged from the LTC home. The severity is determined to be actual harm as the resident remains displaced from the home living in an acute care facility for more than 11 months, impacting their quality of life. The licensee has improperly discharged the resident and has not allowed the resident to return to the home, despite continued compliance orders and a temporary emergency licence being issued to help facilitate the resident's return. The Licensee has a history of noncompliance with this subsection whereby they continue to be noncompliant with s. 145(1) of O. Reg 79/10. CO #001 was re-issued during inspection #2021_805638_0018 and had a compliance due date of August 20, 2021. A CO from another section of the legislation was also issued in the last 36 months.	
This order must be complied with by:	September 14, 2021

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	8th day of September 2021.
Signature of Director:	*Original Signed*
Name of Director:	Brad Robinson