Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d’inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l’inspection	Log # / Registre no	Type of Inspection / Genre d’inspection
Jul 3, 2015	2015_339617_0010	002190-15, 005744-15, 006556-15, 004406-14	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

BIRCHWOOD TERRACE
237 Lakeview Drive R. R. #1 KENORA ON P9N 4J7

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

SHEILA CLARK (617)

Inspection Summary/Résumé de l’inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 4, 5, 6, 7, 8, 2015

The following logs 004406-14, 002190-15, 005744-15, 006556-15 were inspected during the visit to the home.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Office Manager (OM), Environmental Service Manager (ESM), RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

The inspector also conducted a tour of the home, observed resident care, and reviewed resident health care records and staff personnel files.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
2 VPC(s)
0 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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents’ Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents are fully respected and promoted:
Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

Critical Incident System Report was submitted to the Director by the home on August 29, 2014, regarding a mandatory report of staff to resident abuse. Resident reported to the Administrator that while a staff member was providing care, the resident ended up hitting their shoulder against the wall resulting in an injury. An investigation was conducted by the home which included staff and resident interviews, review of health care documents, pictures and security video. The results of the investigation did not provide evidence that abuse occurred. However the staff member involved was expected to re-train on the home's mandatory policies and no longer be assigned to provide care for this resident.

Inspector #617 interviewed the resident, who reported that the staff member still works on the unit on which they live and since the incident does not provide care for them, however does enter the resident's room to answer the call bell at times. Resident reported that they feel uncomfortable when this happens.

In conclusion, the resident lost balance while standing and instead of supporting the resident to the floor safely, the staff member pushed the resident up against the wall to prevent a fall from occurring which resulted in an injury. The resident was not cared for in a manner consistent with their needs. [s. 3. (1) 4.]

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 the following right of all residents are fully respected and promoted:
the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

A Critical Incident System Report was submitted to the Director on April 2, 2015, by the Director of Care regarding a mandatory report of alleged staff to resident abuse. Inspector #617 reviewed the mandatory report and investigation notes which indicated that a staff member witnessed an incident that occurred on on March 29, 2015, and reported it on April 2, 2015. The description of the incident that occurred involved a staff member who was rough and rude while providing care to a resident in the tub room. The resident responded to the incident by refusing to continue with the bath, visibly upset and crying as witnessed by the reporting staff member. Resident requires partial assistance to bathe due to health conditions.

The home conducted an investigation of the incident and concluded that there was evidence of serious misconduct by staff member and rough handling of a resident which constituted abuse. The staff member was terminated and did not return to work at the home.

The reporting staff member reported the incident after 5 days had lapsed. As a result, the alleged staff member was not placed on paid leave of absence pending investigation immediately after the incident. Inspector #617 reviewed the "Staff Sign In Schedule Sheets" for that period of time, which indicated that alleged staff member continued to work in the home jeopardizing the safety of the residents.

2. The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

Critical Incident System report was submitted on April 16, 2015, by the Director of Care (DOC) regarding a mandatory report of alleged staff to resident abuse. Inspector #617 reviewed the investigation notes that the home conducted. A staff member witnessed another staff member throw a pillow at the face of resident and make demeaning comments to resident while providing a transfer back to bed. After resident was transferred back to bed, their request to be toileted was denied. Resident had limited mobility. Inspector #617 reviewed the resident's health care records which identified that the resident requires staff assistance when transferring and is dependent on staff for toileting. The investigation by the home included a signed document describing a witness account of the incident and interviews with resident and staff. The investigation concluded that there was evidence of verbal abuse. The staff member was disciplined and required to complete additional education.

Inspector #617 interviewed the DOC regarding the immediate actions that were taken to prevent recurrence. The DOC reported that the alleged staff member was placed on paid leave of absence immediately after the incident occurred. However, inspector #617 reviewed the Staff Sign In Sheets which indicated that the alleged staff member did in fact work on the unit where the resident resides the next shift after the incident. The dates when the staff member was placed on leave pending investigation were not found documented in the investigation notes. Inspector #617 reviewed the progress notes for the resident which confirmed that the resident was in the building immediately after the incident.

The investigation notes contained a document describing a witness account of a staff member allegedly abusing a resident, during care provision. The witness to the incident did not report the incident immediately instead waited two days according to the dates on

the document. The CIS report indicated that the notification to the director did not occur until 2 days after the incident. The DOC indicated to inspector #617 that the staff member was off with pay pending investigation immediately after the incident occurred when in fact the staff member did work on the unit. The resident was placed at risk while the alleged staff member continued to work and be assigned to resident care. [s. 24. (1)]

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 a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

Issued on this 11th day of August, 2015

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

Original report signed by the inspector.