Ontario

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 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
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 25, 2016	2016_339617_0003	000571-16	Critical Incident System

Licensee/Titulaire de permis

CVH (No.2) LP
c/o Southbridge Care Homes 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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): January 18, 19, 20, 21, 22, 2016

This Critical Incident inspection is related to the following ten critical incidents the home submitted related to:
- allegations of abuse to a resident, Intake #0022719-15, #031770-15, #027908-15, #023204-15, #028340-15, #00571-16, #000334-16, #019057-15
-resident to resident abuse, Intake #000553-16
- resident fall resulting injury and transfer to hospital, Intake #029561-15.

This inspection was conducted concurrently with Follow Up inspection #2016_339617_0004 and Complaint inspection #2016_339617_0005.

Findings of non-compliance regarding mandatory reporting, LTCHA, 2007, S. O. 2007, c. 8, s. 24 (1), were issued in the Follow Up Report #2016_339617_0004.

During the course of the inspection, the inspector(s) spoke with Administrator (AD), Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Resident Services Coordinator (RSC), Environmental Services Manager (ESM), Food Services Manager (FSM), Registered Dietitian (RD), Housekeepers (HSKs), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), residents and family.

Observations were made of the home areas, meal services, and the provision of care and services to residents during the inspection. The home's policies and procedures and resident health records were reviewed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

3 WN(s)
3 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect resident #004 from physical abuse by resident #013.

Critical Incident (CI) report was submitted to the Director in December 2015, which indicated that resident #013 had struck resident #004 resulting in an injury to resident #004.

The Long-Term Care Homes Act, 2007, defined physical abuse subject to section (2) as the use of physical force by a resident that caused physical injury to another resident.

A review of the health care record revealed several occasions during which resident #013 was verbally and physically responsive toward other residents in the home and most of those episodes were physically responsive toward other residents. Documentation of the incidents indicated that resident #013's aggressive responsive behaviour was triggered by specific resident to resident interactions that were common occurrences.

A review of resident #013's care plan identified those specific resident to resident interactions that were known to trigger resident #013's physical response. However there were no interventions identified to maintain the safety of other residents during those specific resident to resident interactions.

During an interview with the DOC they confirmed that resident #013's current care plan did not have interventions to manage resident #013's physically abusive responsive behaviours towards other residents in the home. They also clarified that interventions to manage resident #013's behaviours could have protected against potentially harmful interactions between resident #013 and other residents of the home.

A review of resident #013's health care record indicated that the Behavioural Ontario (BSO) outreach PSW had attended the home to work with resident #013. A review of the Outreach PSW communication log identified that resident #013 did not have time with the BSO PSW for two months due to an expected and scheduled in-availability.

During an interview with the DOC they stated that historically resident #013 was known to have increased episodes of physically responsive behaviours when the BSO PSW was not attendance which put certain residents at a safety risk. The DOC confirmed to the Inspector that the home was aware of the BSO's absence and did not put into place alternative interventions to support resident #013's physically responsive behaviour during those two months.

The home's Abuse Policy, #02-02-04, dated September 2015, indicated that there is zero tolerance of abuse toward a resident and that the home is committed to providing a safe and supportive environment in which all residents are ensured dignity and respect. On January 28, 2016, the Inspector interviewed the DOC who confirmed that certain residents of the home were not safe from the physical responsive behaviours of resident #013.

The recurring harmful interactions of resident #013 towards other residents occurred and the home failed to protect the residents from this unsafe environment. [s. 19. (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 that the licensee of a long-term care home shall protect residents from abuse by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #010 and their substitute decision-maker, if any, were notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

Critical Incident (CI) report was submitted to the Director, which indicated that resident #010 was allegedly neglected by PSW #124.

The home's internal investigation was reviewed by the Inspector. The home's investigation of the incident was completed on August 26, 2015.

A review of the investigation and resident #010's health care record did not indicate any evidence that the substitute decision maker (SDM) was notified of the results of the investigation. On January 21, 2016, the DOC confirmed to the Inspector that the SDM for resident #010 was not notified of the results of their investigation. [s. 97. (2)]

2. The licensee has failed to ensure that resident #009 and their substitute decision-maker, if any, were notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

Critical Incident (CI) report was submitted to the Director, which indicated that resident #009 was allegedly struck by Activity Aide (AA) #125.

The home's internal investigation was reviewed by the Inspector. The home's investigation of the incident was completed by the licensee in July, 2015.

A review of the investigation notes and resident #009's health care record indicated there was not any evidence that the substitute decision maker (SDM) was notified of the results of the investigation. On January 21, 2016, the DOC confirmed to the inspector that the SDM for resident #009 was not notified of the results of their investigation. [s. 97. (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 resident #010, and any other resident residing in the home and their substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee shall ensure that every use of a physical device to restrain resident #011, under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee failed to ensure that the following was documented:
5. the person who applied the device and the time of application
6. all assessment, reassessment and monitoring, including the resident's response
7. every release of the device and all repositioning.

Inspector #617 reviewed the archived health care record for resident #011 which indicated a physician's order, and a signed consent, regarding the use of restraint device while sitting in their wheelchair. The care plan indicated the use of a restraint device and that the device was to be checked hourly for safety, repositioned every two hours and documented that it was in place every shift.

Extendicare policy #RESI-10-01-01 titled, "Physical Restraints", dated November 2012, submitted by the DOC was reviewed and it indicated that registered staff were to initiate all documentation for restraint utilization and care staff were to ensure the "Restraint Record" was completed by documenting the hourly safety checks, two hourly position changes and release of the restraint.

Inspector #617 interviewed PSW #106 who reported that they were responsible to document hourly on the restraint record whether the restraint was applied, repositioned, removed and checked hourly for resident #011's response to the restraint ensuring their safety. Inspector #617 interviewed RPN #115 who reported that they were responsible to document every shift that the restraint for resident #011 was needed and that the PSW applied, repositioned and removed the restraints for resident #011.

Inspector #617 reviewed resident #011's restraint record, and found missing hourly documentation required by the PSW on 90 occasions over eight days; and missing documentation for each shift required by the RPN on 20 occasions over 16 days.

Inspector #617 interviewed the DOC who confirmed that it was the expectation that on the resident's restraint record the registered staff documented the need for the resident restraint every shift and the PSW documented the application, resident response and removal on the restraint record hourly. [s. 110. (7)]

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 every use of a physical device to restrain resident #011 and every other resident residing in the home, under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following is documented:
5. the person who applied the device and the time of application
6. all assessment, reassessment and monitoring, including the resident's response
7. every release of the device and all repositioning, to be implemented voluntarily.

Issued on this 1st day of March, 2016

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

Original report signed by the inspector.