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

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

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

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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
Sep 29, 2016	2016_246196_0011	027704-15, 002072-16, 003470-16, 006744-16, 011449-16	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

LAUREN TENHUNEN (196), KATHERINE BARCA (625)

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): July 11, 12, 13, 14, 15, 2016.

The following intakes were inspected: one related to resident to resident abuse, three related to staff to resident abuse and one related to resident behaviour.

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed staff to resident interactions and the provision of care and services to residents, reviewed submitted Critical Incident System (CIS) reports, reviewed various home policies and procedures, several employee files and resident health care records.

This Critical Incident System inspection was conducted concurrently with a Complaint inspection #2016_246196_0009 and a Follow up inspection #2016_246196_0010.
A finding of non-compliance related to s.6 (7) identified during the CIS inspection was issued in the Follow up Inspection 2016_246196_0010 report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Acting Director of Care, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Activation Assistant and residents.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

On a particular day during the inspection, Inspector #625 observed resident #007 while they were assisted with toileting by PSW #104 without the use of a specific device.

The health care records for resident #007 were reviewed. The current care plan identified that the resident required extensive assistance of two staff members for transfers on and off of the toilet using a specific type of device. The "Resident Lift and Transfer Assessments" from late spring 2016 and early summer 2016, identified that the resident required minimal assistance of one person for transferring during toileting.

During an interview with Inspector #625, the Activation Assistant #105 stated that they had completed the "Resident Lift and Transfer Assessment" and confirmed that the resident required minimal assistance of one staff member for toileting.

During an interview with Inspector #625, the Acting DOC #106 confirmed that resident #007's current care plan identified that the resident required the assistance of two staff members with toileting related transfers using a specific type of device. The Acting DOC also stated that the "Resident Lift and Transfer Assessment" identified that the resident required the assistance of one staff member with toileting related transfers as indicated in the "Resident Lift and Transfer Assessment".

During an interview with Inspector #625, the ED stated that two different staff members completed the "Resident Lift and Transfer Assessment" and updated the care plan. The ED stated that communication about the assessment of the resident's transfer method had not occurred, as a result, the ED stated the resident's plan of care provided unclear directions to staff who provided care to the resident related to toileting assistance. [s. 6. (1) (c)]

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 ensures there is a written plan of care for resident #007 that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the rights of residents were fully respected and promoted, including the right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

On a particular day during the inspection, Inspector #625 observed PSW #104 provide personal care to resident #007 in the resident's shared washroom. The doors to both the resident's room and the washroom were opened, and the resident and PSW were visible in the washroom from the entrance to the room. The Inspector closed the door to the resident's shared bedroom.

During an interview with Inspector #625, PSW #104 stated that they should have closed the door while providing care and would have done so if they knew that someone was coming.

During an interview with Inspector #625, the ED stated that the door should have been closed while staff provided care to resident #007. [s. 3. (1) 1.]

Issued on this 30th day of September, 2016

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

Original report signed by the inspector.