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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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
Mar 1, 2017	2017_633577_0003	027141-16, 027152-16, 027218-16, 027344-16, 027604-16, 027605-16, 027950-16, 030557-16, 032883-16, 033299-16, 034497-16, 034509-16, 034873-16, 034874-16, 035036-16, 035255-16, 000469-17, 000641-17, 000915-17, 001346-17, 002266-17	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

DEBBIE WARPULA (577), LAUREN TENHUNEN (196)

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 30, 31, February 1, 2, 3, 2017.

The following intakes were inspected: 13 logs related to resident to resident abuse; 7 logs related to staff to resident abuse; one log related to a resident hospitalization.

This Critical Incident System inspection was conducted concurrently with a Complaint inspection #2017_633577_0002 and a Follow up inspection #2017_633577_0004.

During the inspection, the Inspectors conducted a walk through of resident care areas, observed staff to resident interactions and the provision of care and services to residents, reviewed various home policies and procedures and reviewed various resident health records and employee files.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Quality Care Coordinator, Behavioural Support Ontario (BSO) Outreach Personal Support Worker and Personal Support Workers (PSW).

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy was complied with.

A Critical Incident System (CIS) report was submitted to the Director for an incident of alleged staff to resident physical abuse which had occurred in December 2016.

According to the report, on a day in December 2016, a family member of resident #008 reported to RN #101, that a staff member was brisk when care was provided to their family member. The staff member had allegedly grabbed the resident and caused injury.

On January 31, 2017, Inspector #196 reviewed the health care records for resident #008. The progress notes dated a day in December 2016, indicated that RN #101 was informed by resident #008's family member of an injury that occurred the previous evening.

The licensee's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting - RC-02-01-01", last revised January 2016, was reviewed. The policy outlined mandatory reporting under the LTCHA and identified that a person must immediately report to the appropriate supervisor in the home on duty (or on call) at the time of a witnessed or alleged incident of abuse or neglect, and notify the Director.

An interview was conducted with the Administrator on January 31, 2017. They reported that RN #101 did not report the incident of staff to resident abuse to a manager at the home and the Director was not notified as per the home's policy. [s. 20. (1)]

2. A CIS report was submitted to the Director in December 2016, for alleged staff to resident physical abuse. The report indicated that a family member of resident #008 reported that during the early morning on a day in December 2016, a staff member had been brisk when providing care and grabbed the resident. As a result, resident #008 had pain and developed an injury.

The LTCHA 2007, identified physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain".

The licensee's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting - RC-02-01-01", last revised January 2016, defined physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain. Their policy also indicated a zero tolerance for abuse, any form of abuse by any person interacting with residents, whether through deliberate acts or negligence, will not be tolerated.

On January 31, 2017, the investigation notes provided by the Administrator, indicated from an interview with resident #008 that RN #100 told them early that they had to get up for a procedure. RN #100 then grabbed them roughly and caused pain. In addition, the staff member had admitted to improperly grabbing the resident while they provided care which resulted in an injury. [s. 20. (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 there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, specifically in regards to resident #008, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was investigated and resolved where possible, and a response was provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

A Critical Incident System (CIS) report was received by the Director in September 2016, concerning alleged neglectful care of resident #003.

Inspector #577 reviewed the investigation notes on February 1, 2017, concerning resident #003 and found that the home met with resident #003's family in September 2016, and the following concerns were made by the family:

-concerns about surgery
-lack of available staff
-lack of quality care

During a further review of the file, Inspector #577 could not find any information concerning an investigation initiated by the home.

A review of the home's policy titled "Complaints and Customer Service - RC-11-01-04" last revised January 2016, indicated the following in regards to verbal complaints:

-initiate an investigation immediately
-interview all staff who may have information related to the complaint
-if the investigation is not completed within ten days, contact the complainant to indicate the investigation is on-going and provide an estimated date of completion
-provide regular updates on the process until investigation is complete
-provide written response at conclusion of investigation, which would include what the home has done to resolve the complaint

During a meeting with the Administrator, they confirmed that the family concerns of neglectful care were not investigated by the home. [s. 101. (1) 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 every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is investigated and resolved where possible, and a response is provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately, to be implemented voluntarily.

Issued on this 2nd day of March, 2017

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

Original report signed by the inspector.