Ontario

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 prévue 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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 9, 2019	2019_633577_0032	021604-19	Complaint

Licensee/Titulaire de permis

CVH (No. 2) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes 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), MELISSA HAMILTON (693)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 25-28, 2019.

The following intake was inspected during this Complaint Inspection:
- One intake related to fall interventions and written complaints.

Additionally, Critical Incident System (CIS) Inspection #2019_633577_0033 was conducted concurrently with this Complaint Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurse (RPN), and a family member.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed complaint logs, reviewed relevant health care records, and reviewed licensee policy procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **4 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	Légende 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 O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented in the home.

A complaint was submitted to the Director, on a specified date, from a family member of resident #001. The complaint outlined concerns with falls prevention interventions, and the response to concerns from the Director of Care (DOC) and the Administrator.

Inspector #693 reviewed the progress notes for resident #001, electronically in PointClickCare (PCC) and identified that the resident had fallen five times, over a specified time period. The progress notes identified that resident #001 fell on five identified dates. The progress notes related to each of the identified falls, indicated that each fall was unwitnessed, and the resident was found on the floor.

Inspector #693 reviewed the home's policy, "Falls Prevention and Management Program - RC-15-01-01", revised August 2019. The policy indicated that if a resident experienced an unwitnessed fall, staff were to have completed a "Clinical Monitoring Record." The policy also directed staff to assess the following; for 72 hours post fall, at each shift: pain, bruising, change in functional status, change in cognitive status, and changes in range of motion. The Inspector reviewed, "Appendix 6, Clinical Monitoring Record." The Clinical Monitoring Record indicated that Neurovital signs, vital signs, pain assessments, and changes in behaviour were to be monitored every hour, for four hours, and every eight

hours, for 72 hours.

Inspector #693 reviewed the assessments in PCC for resident #001, over a specified time period. The Inspector identified that for each of the five falls that resident #001 had during the identified time period, a specific assessment record was not completed at the specific time intervals post-fall. The assessment record entries that were completed, were not consistent with, and did not correspond to the dates and times of the falls, as they should have been in accordance with the directions indicated on the specific assessment record. Some of the times that the entries were recorded were for times before the fall had occurred, or dates that were several days after the fall; consequently, the documentation of the assessment records for each of resident #001's falls were not decipherable.

Inspector #693 reviewed the resident's medical chart and identified a paper copy of a specific assessment record for resident #001's fall on a specified date. A particular assessment section of the form was left blank, and a particular section of the form had dates and times that were not corresponding to the specific time intervals, post-fall, written in pen; below each of these outlined times, there was a vertical line drawn across the page, with no vital signs recorded; and for one time, it was indicated that the resident was sleeping.

During an interview with RPN #101, they stated that when a resident had an unwitnessed fall, Registered staff were to complete the specific assessment record, on both paper and electronically in PCC.

During an interview with RN #100, they identified that they were the Falls Lead for the home. The RN indicated that Registered staff were to complete the specific assessment record, after an unwitnessed fall, electronically in PCC, but that some staff liked to have the paper copy as a reference and that is why they drew lines down the page. RN #100 reviewed the PCC documentation and indicated that resident #001 fell on a specified day. RN #100 reviewed the paper copy of the specific assessment record for resident #001's fall on a specified date, and stated that the times that were written in pen were not accurate, and that the form was not completed as it should have been. RN #100 reviewed the specific assessment records for resident #001, in PCC, and stated that for each of the five falls, that resident #001 had between a specified time period, the specific assessment records were not completed as they should have been, post-fall. The RN indicated that in some instances, they suspected that staff did not know how to document properly, related to the time of documentation, and that it was impossible to tell when the

specific assessment records were completed, as the dates and times did not seem accurate.

During an interview with the Acting Director of Care (ADOC), they reviewed the falls documentation for resident #001, on five specific dates. The ADOC stated that the specific assessment records were not completed appropriately at the specific time intervals post-fall; as well, the post-fall monitoring of the resident was not documented appropriately; two other specific fall assessments should have been completed after each of the five falls, and that these assessments were not completed. The ADOC identified that it was evident to them that the staff were not aware of how to implement aspects of the Falls Prevention and Management program. [s. 48. (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 an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury is developed and implemented in the home, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A complaint was submitted to the Director on a specified date, from a family member of resident #001. The complainant had concerns relating to falls prevention interventions for resident #001, and the response to concerns from the Acting Director of Care (ADOC) and the Administrator.

Inspector #693 reviewed the progress notes for resident #001, electronically in PointClickCare (PCC) and identified that the resident had fallen five times over a specified time period. The progress notes identified that resident #001 fell on five specified dates.

Inspector #693 reviewed the assessments in PCC for resident #001 over a specified time period. The electronic assessments identified that a specific fall assessment from a specified date, was not completed in full, as it did not include the resident's fracture risk, the resident's most recent fall risk level, the root cause of the fall, a follow up plan and recommendations, or identification of medications the resident received in the 12 hours prior to falling. In review of the assessments tab, Inspector #693 identified that there was no Post Falls Assessment present for resident #002's fall on another specified date.

During an interview with RN #100, they identified that they were the Falls Lead for the home. The RN indicated that when a resident has fallen, the RN or RPN was responsible for completing a Post Falls Assessment in PCC, in entirety; that included ensuring that all areas of the assessment tool were completed. The RN stated that the Post Falls Assessment for resident #001, was not completed appropriately on a specified date, and that a Post Falls Assessment was not completed on another specified date.

Inspector #693 reviewed the home's policy, titled, "Falls Prevention and Management Program, RC-15-01-01", last updated in August 2019. The policy indicated that if a resident had fallen, Registered staff were to complete the Post Falls Assessment tool.

During an interview with the ADOC, they reviewed resident #001's assessments on PCC, and confirmed that the Post Falls Assessment was not completed appropriately or at all, when resident #001 had fallen on two specified dates. [s. 49. (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 when a resident falls, the resident is assessed and that where the condition or circumstances of the resident required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #3: 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).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

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 was investigated and resolved where possible, and a response that complied with paragraph 3 provided within 10 business days of the receipt of the complaint.

A complaint was submitted to the Director, on a specified date, from a family member of resident #001. The complaint outlined concerns with specified interventions, and the response to concerns from the Director of Care (DOC) and the Administrator.

During an interview with the family member of resident #001, they indicated to Inspector #693 that they had submitted several written electronic mail (email) complaints, regarding care concerns for resident #001, to the Administrator, and some to the Senior Directors for the licensee. The family member stated that they were not sure if an investigation was completed in relation to their complaints, and that the management members whom they had emailed did not seem to take actions, regarding some of their submitted complaints.

Inspector #693 obtained copies of email complaints and concerns from the family member of resident #001, from the Administrator. The emails were sent from the family member to the following management members, and outlined the following care concerns on the following dates:

- on a day in October 2019, email to the previous Regional Director-Extendicare Assist, regarding concerns related to staffing;
- over a specified time period, a chain of emails to the previous Regional Director-Extendicare Assist, the Regional Manager Clinical Services and the Administrator, regarding concerns related to resident #001's specific monitoring devices;
- on a day in November 2019, email to the Administrator, regarding concerns related to resident #001's specific monitoring devices;
- on another day in November 2019, email to the previous Regional Director-Extendicare Assist, the Regional Manager Clinical Services and the Administrator, regarding concerns related to resident #001's specific monitoring devices; and
- on another day in November 2019, email to the Administrator, regarding concerns related to resident #001's specific monitoring devices.

Inspector #693 reviewed the five email threads of each of the outlined written email complaints. There was no email message sent back to resident #001's family member, to inform of them of an investigation or results of an investigation, for the email complaints received on three specified dates in November 2019 .

Inspector #693 reviewed the home's policy, "Complaints and Customer Service - RC-09-01-04", revised June 2019. The policy indicated that the Administrator was to initiate an investigation into the circumstances leading to the complaint within 24 hours and an investigation was to be completed within 10 days, and if not within 10 days the complainant was to be contacted to inform them that the investigation was ongoing and provided an estimated date of completion of investigation, as well as to have provided the complainant with regular updates on the process until investigation was completed. The policy also indicated that once the investigation was concluded the Administrator was to provide a written response to the complainant that would include what the home did to resolve the complaint, and if the complaint was unfounded the reasons why this conclusion was reached.

During an interview with the Administrator, they acknowledged the written complaints they had received from resident #001's family member, regarding care concerns for resident #001. The Administrator stated that the complaints received over a specific time period in November 2019, had not been investigated by the home and consequently the complainant was not informed of the investigation or the results of the investigation. [s. 101. (1) 1.]

2. The licensee has failed to ensure that a documented record was kept in the home that included, the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant.

A complaint was submitted to the Director, on a specified date, from a family member of resident #001. The complaint outlined concerns with the resident's specified interventions, and the response to concerns from the Director of Care (DOC) and the Administrator.

During an interview with the family member of resident #001, they indicated to Inspector #693 that they had submitted several written electronic mail (email) complaints, regarding care concerns for resident #001, to the Administrator, and some to Senior Directors for the licensee. The family member stated that they were not sure if an investigation was completed in relation to their complaints, and that the management members whom they had emailed did not seem to take actions, regarding some of their submitted complaints.

Inspector #693 obtained copies of email complaints and concerns from the family member of resident #001, from the Administrator. The emails were sent from the family member to the following management members, and outlined the following care concerns on the following dates:

- on a day in October 2019, email to the previous Regional Director-Extendicare Assist, regarding concerns related to staffing;
- over a specified time period, a chain of emails to the previous Regional Director-Extendicare Assist, the Regional Manager Clinical Services and the Administrator, regarding concerns related to resident #001's specific monitoring devices;
- on a day in November 2019, email to the Administrator, regarding concerns related to resident #001's specific monitoring devices;
- on another day in November 2019, email to the previous Regional Director-Extendicare Assist, the Regional Manager Clinical Services and the Administrator, regarding concerns related to resident #001's specific monitoring devices; and
- on another day in November 2019, email to the Administrator, regarding concerns related to resident #001's specific monitoring devices.

Inspector #693 reviewed the home's Complaint Log for the last year. The Inspector noted that none of the email complaints, made to the home, by resident #001's family member were included in the Complaint Log.

Inspector #693 reviewed the home's policy, "Complaints and Customer Service - RC-09-01-04", revised June 2019. The policy indicated that the home was to maintain a record of all complaints and actions taken in the Complaint Log, and to retain written investigation records and keep them in one location.

During an interview with the Administrator, they acknowledged the written complaints that were received from resident #001's family member, were not included in the home's Complaints Log. The Administrator stated that they did not keep record of the nature of these complaints, the dates the complaints were received, the type of action that was taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required. [s. 101. (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 every written or verbal complaint made to the licensee or a staff member concerning the care of a resident is 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 to ensure that a documented record is kept in the home that includes, the nature of each verbal or written complaint; the date the complaint is received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response is provided to the complainant and a description of the response; and any response made in turn by the complainant, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that when they received a written complaint concerning the care of a resident or the operation of the long-term care home they immediately forwarded it to the Director.

A complaint was submitted to the Director on a specified date, from a family member of resident #001. The complaint outlined concerns with specified interventions, and the response to concerns from the Director of Care (DOC) and the Administrator.

During an interview with the family member of resident #001, they indicated to Inspector #693 that they had submitted several written electronic mail (email) complaints, regarding

care concerns for resident #001, to the Administrator, and some to Senior Directors for the licensee. The family member stated that they were not sure if an investigation was completed in relation to their complaints, and that the management members whom they had emailed did not seem to take actions, regarding some of their submitted complaints.

Inspector #693 obtained copies of email complaints and concerns from the family member of resident #001, from the Administrator. The emails were sent from the family member to the following management members, and outlined the following care concerns on the following dates:

- on a day in October 2019, email to the previous Regional Director-Extendicare Assist, regarding concerns related to staffing;
- over a specified time period, a chain of emails to the previous Regional Director-Extendicare Assist, the Regional Manager Clinical Services and the Administrator, regarding concerns related to resident #001's specific monitoring device;
- on a day in November 2019, email to the Administrator, regarding concerns related to resident #001's specific monitoring device;
- on another day in November 2019, email to the previous Regional Director-Extendicare Assist, the Regional Manager Clinical Services and the Administrator, regarding concerns related to resident #001's specific monitoring device; and
- on another day in November 2019, email to the Administrator, regarding concerns related to resident #001's specific monitoring device.

Inspector #693 reviewed the home's policy, "Complaints and Customer Service - RC-09-01-04", revised June, 2019. The policy indicated that the Administrator was responsible for ensuring that complaint documentation was forwarded to provincial, regional, local health and/or other authorities as required, and to forward a copy of the written complaint and response to the appropriate regulatory body.

During an interview with the Administrator, they acknowledged the written complaints they had received from resident #001's family member, regarding care concerns for resident #001. The Administrator stated that none of the complaints had been submitted to the Director and Ministry of Long Term Care, as the Administrator was not aware of this requirement. [s. 22. (1)]

Issued on this 11th day of December, 2019

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

Original report signed by the inspector.