Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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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
Jun 23, 2020	2020_829757_0006	001684-20, 002016-20	Critical Incident System

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

DAVID SCHAEFER (757), KEARA CRONIN (759), LAUREN TENHUNEN (196), LOVIRIZA CALUZA (687)

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): March 2-6 and 9-12, 2020.

The following intakes were inspected during this Critical Incident System inspection:
- Two intakes related to alleged staff-to-resident abuse.

This inspection was conducted concurrently with Complaint inspection #2020_829757_0008 and Follow up inspection #2020_829757_0007.

PLEASE NOTE:
- Non-compliance related to s. 104 (1) 2. of O. Reg. 79/10 was identified during this inspection, and a Compliance Order (CO) was reissued in Follow up inspection report #2020_829757_0007, which was conducted concurrently with this inspection.
- Non-compliance related to s. 19 (1) of the Long-Term Care Homes Act, 2007, was identified during this inspection, and a CO and Director Referral (DR) was issued in Complaint inspection report #2020_829757_0008, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Acting Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Office Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, staff-to-resident interactions, and reviewed relevant resident health care records, internal investigation notes, as well as specific licensee policies, procedures, and programs.

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

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

- **1 WN(s)**
- **0 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 LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of an investigation undertaken due to an alleged incident of abuse of a resident were reported to the Director.

A Critical Incident System (CIS) report was submitted to the Director as a result of an alleged incident of staff-to-resident sexual abuse involving resident #005.

Inspector #759 reviewed the home's policy titled "Zero Tolerance of Abuse and Neglect: Investigation and Consequences – RC-02-01-03", last updated June 2019. The policy stated that "investigation results will be shared with key stakeholders, including, residents, families, staff, and relevant regulatory authorities".

Inspector #759 reviewed the home's internal investigation notes related to the incident, which indicated that the police investigation into the case had been closed as a result of a specified development.

On March 5, 2020, at 0900 hours, Inspector #759 reviewed the CIS report related to the incident and identified that the results of the investigation had not yet been amended.

During an interview with the Director of Care (DOC), on March 5, 2020, at 0930 hours, they indicated that they had amended the results of the investigation on the CIS report. At that time, Inspector #759 reviewed the Long-Term Care Homes Portal, and identified that CIS report had not yet been amended with the results of the investigation to indicate that the police investigation had been closed as a result of the specified development.

On March 5, 2020, at 1006 hours, Inspector #759 observed the Acting DOC amend the results of the investigation during an interview. The Acting DOC recognized that the amendment of the CIS report to include the results of the investigation was late. [s. 23. (2)]

Issued on this 3rd day of July, 2020

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

Original report signed by the inspector.