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

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 rapport public

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_0007	023436-19, 023437-19	Follow up

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

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

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): March 2-6 and 9-12, 2020.

The following intakes were inspected during this Follow up inspection:
- Follow-up intake for Compliance Order (CO) #001, issued during inspection #2019_633577_0033 under s. 212 (4) of Ontario Regulation (O. Reg.) 79/10, related to Administrator qualifications.
- Follow-up intake for CO #002, issued during inspection #2019_633577_0033 under s. 104 (1) of O. Reg. 79/10, related to reporting of alleged, suspected, or witnessed incidents of abuse and neglect.

This inspection was conducted concurrently with Complaint inspection #2020_829757_0008 and Critical Incident System inspection #2020_829757_0006.

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, and Office Manager.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, and reviewed relevant internal investigation notes, documents related to Administrator qualifications, 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
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 212. (4)	CO #001	2019_633577_0033	757

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. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee has failed to include a description of the individuals involved in incidents of alleged abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report, including names of any staff members or other persons who were present at or discovered the incident, when making a report to the Director under subsection 23 (2) of the Act.

Compliance Order (CO) #002 was issued to the home on December 9, 2019, in inspection report #2019_633577_0033, with a compliance due date of February 3, 2020. The home was ordered to be compliant with subsection 104 (1) of Ontario Regulation 79/10. Specifically, the home was ordered that they must:
1) Ensure that all alleged, suspected or witnessed incidents of abuse of a resident by anyone or neglect of a resident by the licensee or staff were investigated and reported to the Director.
2) Ensure that the report to the Director contained the following:
- A description of the incident, including the type of incident, the area or location of the

incident, the date and time of the incident and the events leading up to the incident;
- A description of the individuals involved in the incident, including the names of all residents involved in the incident, the names of any staff members or other persons who were present at or discovered the incident;
- The names of any staff members or other persons who were present at or discovered the incident, and the names of staff members who responded or are responding to the incident;
- Actions taken in response to the incident, including, what care was given or action taken as a result of the incident, and by whom; whether a physician or registered nurse in the extended class was contacted; what other authorities were contacted about the incident, if any, and whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons;
- The outcome or current status of the individual or individuals who were involved in the incident;
- Analysis and follow-up action, including, the immediate actions that have been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence;
- The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.

Inspector #759 reviewed the home’s policy titled “Critical Incident Reporting (ON) – RC-09-01-06”, last updated June 2019. The policy indicated that “the home will report and submit all Mandatory and Critical Incidents to the Ministry of Health and Long-Term Care, within the required time frames, in accordance to the Ontario Long-Term Care Homes Act, 2007”.

The Inspector reviewed the document titled “Cheat Sheet – Things to include in your Critical Incident report” which stated to “please make sure that you that you use full names for residents and staff members”.

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

Inspector #759 reviewed the home's internal investigation notes related to the incident, and identified Personal Support Worker (PSW) #109 as the staff member who was alleged to have sexually abused resident #005.

Inspector #759 reviewed CIS report and could not identify PSW #109's full name in the report.

During an interview, Inspector #759 reviewed the CIS report with the Acting Director of Care (DOC). They indicated that PSW #109's full name had not been included in the CIS report submitted to the Director, and that it should have been.

b) A CIS report was submitted to the Director as a result of an alleged incident of staff-to-resident abuse.

Inspector #759 reviewed the home's internal investigation notes related to the incident. The investigation notes identified that PSW #105 was involved in the incident and was alleged to have thrown an item at resident #006.

Inspector #759 reviewed the CIS report and could not identify PSW #105's full name in the report.

During an interview, Inspector #759 reviewed the CIS report with the Acting DOC. They indicated that PSW #105's full name had not been indicated in the CIS report submitted to the Director, and that it should have been.

c) A complaint was submitted by resident #004's family member to the Director which outlined alleged neglect of care regarding a fall of the resident.

Inspector #687 conducted a review of the home's internal investigation notes and the CIS report submitted to the Director. The Inspector identified PSW #107 as the staff member who was alleged to have neglected the care of resident #004, resulting in a fall. A second PSW staff member involved in the incident was not identified by name in the CIS report.

In an interview with PSW #107, they stated that they provided a specified type of care to resident #004 with PSW #115. However, while providing care, they indicated that PSW #115 had to leave the room to attend to a phone call.

During an interview with Registered Nurse (RN) #106, they stated that resident #004 required two staff to assist with a specified type of care and verified that there were two PSWs who had initially assisted the resident with their care on the day of the fall.

In an interview with the Acting DOC, they verified that PSW #107 and #115 provided care to resident #004 on the day of the fall. The Acting DOC acknowledged that they did not include the name of PSW #115 in the CIS report. [s. 104. (1) 2.]

2. The licensee has failed to ensure that a report was made within 10 days of becoming aware of an alleged incident of abuse of a resident by anyone, or at an earlier date if required by the Director.

A CIS report was submitted to the Director, as a result of an alleged incident of staff-to-resident abuse.

Inspector #759 reviewed the CIS report related to the incident. The report indicated that it had not been submitted to the Director until five business days after the incident.

Inspector #759 reviewed the home's policy titled "Critical Incident Reporting (ON) – RC-09-01-06" last updated June 2019, which indicated that "the home will report and submit all Mandatory and Critical Incidents to the Ministry of Health and Long-Term Care, within the required time frames, in accordance to the Ontario Long Term Care Homes Act, 2007".

Review of a memo from the Director to Long-Term Care Homes titled "Clarification of Mandatory and Critical Incident Reporting Requirements", last amended August 31, 2018, identified that when an incident of abuse of a resident by anyone which resulted in harm or a risk of harm occurred outside of regular business hours, the home was required to call the After Hours reporting line, followed by a CIS report "first thing the following business day".

Review of an After Hours call report identified that the home had called the Ministry of Long-Term Care's After Hours reporting line to make an initial report of the alleged incident of abuse on the evening it occurred.

During an interview, the Acting DOC indicated to Inspector #759 that if the after-hours line was called to report an incident of abuse, a CIS report was required to be submitted the following business day. They confirmed that this CIS report should have been submitted the following business day. [s. 104. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 3rd day of July, 2020

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DAVID SCHAEFER (757), KEARA CRONIN (759), LAUREN TENHUNEN (196), LOVIRIZA CALUZA (687)
Inspection No. / No de l'inspection :	2020_829757_0007
Log No. / No de registre :	023436-19, 023437-19
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jun 23, 2020
Licensee / Titulaire de permis :	CVH (No. 2) LP 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Birchwood Terrace 237 Lakeview Drive, R.R. #1, KENORA, ON, P9N-4J7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Marva Griffiths

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To CVH (No. 2) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2019_633577_0033, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:

1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

Order / Ordre :

The licensee must comply with s. 104 (1) of Ontario Regulation 79/10.

Specifically, the licensee must ensure that every alleged, suspected, or witnessed incident of abuse of a resident by anyone, or neglect of a resident by the licensee or staff is reported to the Director, and the report includes the following material in writing:

A description of the individuals involved in the incident, including:
- Full names of any staff members or other persons who were present at or discovered the incident, and
- Full names of staff members who responded or are responding to the incident.

Grounds / Motifs :

1. The licensee has failed to include a description of the individuals involved in incidents of alleged abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report, including names of any staff members or other persons who were present at or discovered the incident, when making a report to the Director under subsection 23 (2) of the Act.

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- The names of any staff members or other persons who were present at or discovered the incident, and the names of staff members who responded or are responding to the incident;
- Actions taken in response to the incident, including, what care was given or

action taken as a result of the incident, and by whom; whether a physician or registered nurse in the extended class was contacted; what other authorities were contacted about the incident, if any, and whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons;
- The outcome or current status of the individual or individuals who were involved in the incident;
- Analysis and follow-up action, including, the immediate actions that have been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence;
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In an interview with the Acting DOC, they verified that PSW #107 and #115 provided care to resident #004 on the day of the fall. The Acting DOC acknowledged that they did not include the name of PSW #115 in the CIS report.

The decision to re-issue a CO was based on the scope of the identified non-compliance, which was a level 3, indicating the issue was widespread. The severity of the issue was a level 1, indicating no harm. The home's compliance history related to the issue was a level 4, indicating a re-issued CO related to the same subsection and a history of three or fewer COs:
- CO #002 issued December 9, 2019, in inspection report #2019_633577_0033, with a compliance due date of February 3, 2020;
- WN issued May 13, 2019, in inspection report #2019_624196_0010. (759)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Aug 05, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 23rd day of June, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : David Schaefer

Service Area Office /
Bureau régional de services : Sudbury Service Area Office