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 29, 2021	2021_879621_0006	004758-21	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

JULIE KUORIKOSKI (621)

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): June 21 - 24, 2021.

The following intake was inspected during this Critical Incident System (CIS) inspection:

One intake related to responsive behaviour management.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care (Acting DOC), the Nurse Practitioner (NP), Registered Practical Nurses (RPNs), Personal Support Workers, (PSWs), the Infection, Prevention and Control (IPAC) Lead, the Maintenance Supervisor, a Housekeeping Aide (HA), and residents.

The Inspector also conducted daily tours of the resident care areas, observed the provision of care and services to residents, and reviewed the home's supporting documentation and relevant resident health care records.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **1 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	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee shall ensure that care set out in the plan of care was provided, as specified in the plan.

A Critical Incident System (CIS) report was received by the Director, concerning a resident-to-resident altercation, resulting in injury.

A review of the home's healthcare records for two identified residents, indicated a further resident-to-resident altercation, resulting in injury on a subsequent date. The most current care plans for both residents prior to the most recent incident, identified that each resident required a specified care management strategy to be in place.

During interviews with the Acting DOC and Administrator, they confirmed that care plans in effect for both residents prior to the second incident, included a specified care management strategy. They also confirmed that as a result of the second incident between the two residents, the plan of care for for each resident had not been provided as specified in the plan.

Sources: A CIS report, progress notes and behavior care plans for two residents, and interviews with the Acting DOC, Administrator and other relevant staff. [s. 6. (7)]

2. The licensee shall ensure that resident care plans were reviewed and revised at least every six months, and at any other time when the resident's care needs change, or the care set out in the plan of care was no longer necessary.

a) A CIS report was received by the Director, concerning a resident-to-resident altercation, resulting in injury.

During a review of the most current care plan for one resident, it identified two specific care management strategies were to be in place.

Observations made of the resident during the inspection, found the resident did not participate in either care strategy as identified.

During an interview with an RPN, they reported that the identified resident, did not utilize or require either care management strategy found in their plan of care, and consequently the care plan had not been revised to reflect the resident's care needs.

During interviews with the Acting DOC and Administrator confirmed that the resident's care plan had not been revised to reflect the resident’s current care needs.

b) Further review of one resident's healthcare record identified an altercation between themselves and another resident on a specified date.

On review of the resident's care plan, it identified that they and another named resident were to have a specific care strategy in place to reduce risk of altercation. However, on review of the other resident's care plan, this same strategy was not documented.

During an interview with an RPN, they reported that the two identified residents had an altercation on a specified date, and on review of the most current care plan for both residents, a specific care strategy was identified under one resident's care plan, but not the other resident's care plan, and should have, after the most recent incident.

During an interview with the Administrator they reported that the registered nursing staff were responsible for making any updates to the resident's care plan, in consultation with the interdisciplinary team, as required. They also confirmed that the care plan for the resident in question, had not been revised to reflect the resident’s current care needs, and should have been.

Sources: A CIS report, progress notes and behavior care plans for two residents, Extendicare Plan of Care policy. and interviews with an RPN, Acting DOC, Administrator and other relevant staff. [s. 6. (10) (b)]

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 care set out in the plan of care is provided as specified in the plan; and to ensure that behavioural care plans for resident's are reviewed and revised at least every six months, and at any other time when the resident's care needs change, or the care set out in the plan of care is no longer necessary, to be implemented voluntarily.

Issued on this 29th day of June, 2021

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

Original report signed by the inspector.