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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
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159 rue Cedar Bureau 403
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Téléphone: (705) 564-3130
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 8, 2017	2017_633577_0002	030363-16, 032465-16, 034674-16	Complaint

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), KATHERINE BARCA (625)

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): January 30, 31, February 1, 2, 3, 2017.

The following intakes were inspected: one log related to a complaint regarding staffing and environmental concerns, one log related to a complaint regarding staffing concerns and resident care concerns and one log related to a complaint regarding staffing concerns.

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, reviewed staffing schedules and resident health records.

This Complaint inspection was conducted concurrently with a Critical Incident System inspection #2017_633577_0003 and a Follow up inspection #2017_633577_0004.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurses (RPN), Housekeeping Aide, Ward Clerk, Environmental Services Supervisor (ESS) and a family member.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 VPC(s)**
- **1 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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home on duty and present in the home at all times, except as provided for in the regulations.

Complaints were received by the Director regarding the lack of a registered nurse (RN) on site in the home on two specific dates in November of 2016. One of the complainants alleged that, on a day in November 2016, there was no RN on site, no Director of Care in place and the Executive Director had been on vacation. On that day, a concern regarding resident #001 not receiving morning care or breakfast was brought forward by resident #001's family member and they were unable to report the complaint to an appropriate staff person as none were on site.

A review of a list provided by the Ward Clerk/Scheduler to Inspector #625 included the dates and shifts that the home was without an RN. The list identified that the home had been without an RN on site in the home for 24 twelve-hour shifts over a three month period, or 13 percent of the scheduled RN shifts. Inspector #625 reviewed Ontario Regulation 79/10 s. 45. (2) (ii) and identified that during the identified time period the licensee did not meet the exemption requirements.

On January 31 and February 1, 2017, Inspector #625 did not observe an RN in the home at multiple times throughout the day shifts.

On January 31, 2017, during an interview with Inspector #625, RPN #101 stated that an RN was not on site but was "on call" from 0700 hours to 1900 hours that day.

On February 1, 2017, during an interview with Inspector #625, RPN #102 stated that there was no RN on site from 0700 hours to 1300 hours but that an RN was "on call" during that time.

On February 1, 2017, during an interview with Inspector #625, RN #103 stated that there had been no RN on site in the home from 0700 hours to 1300 hours and that they had been "on call" as they had been available by phone to provide advice and could come in to the home if required. The RN also stated that they had been on call on Sunday January 29, 2017, when they had attended the home 30 minutes after being called by the staff to monitor the dining room as it was unsafe without the RN being present to monitor the residents. The RN stated that, in the absence of an on site RN in the home, the RPNs would try to get as many treatments as possible done and would generally try to get done what was necessary.

On February 1, 2017, during an interview with Inspector #625, RN #103 and RPN #102 stated that three treatments were displayed on the eTAR as not having been completed that day, when an RN had not been on site.

During an interview with Inspector #625 on February 1, 2017, RPN #105 stated that they had not been able to complete the three outstanding treatments identified on the eTAR as they had been supervising the dining room and did not have enough time to complete the treatments.

During an interview with Inspector #625 on February 2, 2017, RPNs #104 and #105 both stated that they had worked when there had been no RN on site in the home.

During interviews with Inspector #625 on January 31 and February 2, 2017, the Executive Director (ED) stated that there were times that the home operated without an RN on site and confirmed that the shifts listed by the Ward Clerk/Scheduler were in fact the dates and shifts where the home had operated without an RN on site. The ED stated that, on a day in November 2016, they had taken a day off when they had been alerted to a family's concerns by the Ward Clerk/Scheduler. They stated that they had come into the home at approximately 1100 hours, once they were made aware that the family had a complaint. The ED confirmed that the RN role included completing treatments, monitoring the basement dining room and responding to emergency situations when they arose. [s. 8. (3)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The home has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

The Director received a complaint related to dirt and dust accumulation under furniture in residents' rooms.

On January 31, 2017, Inspector #625 made the following observations of resident rooms:
- debris and dust underneath the headboard of a resident bed;
- 20 peanuts underneath the head of a resident bed;
- dirt and debris collected between two dressers against the wall covering an area of approximately two cm x 60 cm;
- the floor underneath the headboards to have dust, coloured string and black debris present; and
- black hairs, black debris and a brown bead behind a chair near the window.

On February 1, 2017, Inspector #625 observed the same dirt, debris and items observed on January 31, 2017. In addition, what appeared to be a small sticker had also accumulated on the floor underneath a headboard in a resident room.

On February 2, 2017, Inspector #625 observed the same dirt, debris and items observed on January 31, 2017. In addition, a small shiny brown object had also accumulated on the floor underneath a headboard in a resident room.

During an interview with Inspector #625 on February 1, 2017, at 1402 hours, Housekeeping Aide #106 stated that the Housekeeping staff did the best they could with respect to keeping the floors clean in resident rooms and showed the Inspector a sheet where washing floors/spot washing floors was listed for each room as a task to be completed.

During an interview with Inspector #625 on February 2, 2017, the Environmental Services Supervisor (ESS) #107 stated that the Housekeeping staff had difficulty moving dressers to clean behind them and would need to notify the ESS if dressers had to be moved for cleaning. The ESS stated that the dirt, debris and small objects observed by the Inspector over the course of three days should have been swept away as sweeping should be completed daily of residents' rooms. [s. 15. (2) (a)]

WN #3: 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, upon receipt of a written complaint concerning the care of a resident or the operation of the long-term care home, the written complaint was immediately forwarded to the Director.

A complaint was received by the Director that alleged resident #001 had not been provided with morning care or breakfast until after 1010 hours, when the resident's family member arrived at the home and approached staff about the lack of care provided to the resident.

On January 31, 2017, during an interview with Inspector #625, resident #001's family member stated that they had multiple concerns about resident #001 being forgotten about by the PSW assigned to provide care to the resident, resulting in a lack of morning care and failure to provide the resident with breakfast until the family member arrived in the home after 1010 hours and began making inquiries. The family member stated that they provided their complaint to the Executive Director of the home in writing.

Inspector #625 reviewed the undated complaint provided by resident #001's family member to the Executive Director about the incidents that occurred in November 2016. The complaint was signed by the family member and detailed that, when the family member arrived in the home that day at 1010 hours they observed that:
- resident #001 was observed attempting to reach their call bell that was not within sight or reach of the resident;
- morning care had not been provided to resident #001;
- resident #001 had not been provided with breakfast;
- the PSW assigned to provide care to resident #001 had not done so as they lost the list of residents under their care;
- there was no RN on duty and present in the home at that time;

- the home did not have a Director of Care in place at that time; and
- the Executive Director had been on vacation leaving no one in the building who could address the family member's complaints.

During an interview with Inspector #625 on February 1, 2017, the Executive Director (ED) stated that they had been informed of the verbal complaint the family had about resident #001's care at the time that it occurred, as they were on vacation but attended the home after the Ward Clerk/Scheduler notified them of the complaint. The ED stated that they requested the family member provide the complaint to the home in writing. The ED provided the Inspector with the undated letter of complaint and acknowledged that they had not forwarded the written complaint to the Director. [s. 22. (1)]

Issued on this 8th day of March, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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 Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBBIE WARPULA (577), KATHERINE BARCA (625)
Inspection No. / No de l'inspection :	2017_633577_0002
Log No. / Registre no:	030363-16, 032465-16, 034674-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 8, 2017
Licensee / Titulaire de permis :	CVH (No.2) LP c/o Southbridge Care Homes, 766 Hespeler Road, Suite 301, 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 :	Wendy Sarfi

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee is ordered to ensure that there is at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home on duty and present in the home at all times, except as provided for in the regulations.

Grounds / Motifs :

1. The licensee has failed to ensure that there was at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home on duty and present in the home at all times, except as provided for in the regulations.

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Previous non-compliance related to this legislation, LTCHA 2007, S.O. 2007, c. 8, s. 8. (3) was issued during the following inspections:

October 18, 2016 - Written Notification/Voluntary Plan of Correction issued from Inspection #2016_246196_0009;
March 10, 2016 - Written Notification/Voluntary Plan of Correction issued from Inspection #2016_339617_0004.

The decision to issue this Compliance order was based on the scope which resulted in a pattern, the severity which indicated minimal harm or potential for actual harm and the compliance history.

Despite the issuance of two Written Notification/Voluntary Plan of Corrections in the past year, the licensee continues to be in non-compliance with s. 8. (3). (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 22, 2017

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 or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 8th day of March, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Debbie Warpula

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