



**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**

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**Public Copy/Copie du public**

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<b>Report Date(s) / Date(s) du rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Jun 1, 2018	2018_624196_0013	009504-17, 015466-17, 018066-17	Critical Incident System

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**Licensee/Titulaire de permis**

CVH (No. 2) LP

766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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**Long-Term Care Home/Foyer de soins de longue durée**

Birchwood Terrace

237 Lakeview Drive, R.R. #1 KENORA ON P9N 4J7

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**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

LAUREN TENHUNEN (196), JULIE KUORIKOSKI (621), LOVIRIZA CALUZA (687)

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**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): April 23 - 27, 2018**

**The following intakes were inspected during this Critical Incident System Inspection:**

**Two intakes related to alleged staff to resident abuse; and  
one intake related to resident to resident abuse.**

**A Complaint inspection #2018\_624196\_0011 and a Follow Up inspection #2018\_624196\_0012 was conducted concurrently with this Critical Incident System inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Ward Clerk/Scheduler, residents and family members.**

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

**The following Inspection Protocols were used during this inspection:  
Prevention of Abuse, Neglect and Retaliation  
Responsive Behaviours**

**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	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24.  
Reporting certain matters to Director**



**Specifically failed to comply with the following:**

**s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:**

- 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone, or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, immediately reported the suspicion and the information upon which it was based to the Director.

A Critical Incident System (CIS) report was submitted to the Director in 2017 for a mandatory report of improper/incompetent treatment of a resident that resulted in harm or risk to a resident. The report identified that on a specific date in 2017, PSW #102 notified the DOC that PSW #121 was rude towards resident #004 during morning care. Specifically, it was reported that when PSW #121 and PSW #102 were providing care to resident #004, PSW #102 observed resident #004's reaction and PSW #121 responded with a statement. PSW #102 further reported that when they then took resident #004 into the lounge, the resident looked upset.

During an interview with PSW #102, they stated to Inspector #621 that they recalled the incident where they observed PSW #121 speak rudely to resident #004 during care, and that they then reported the incident to the DOC.

During an interview with the DOC, they confirmed that the outcome of their investigation determined that PSW #121 had verbally abused resident #004, and that although they had been made aware of the alleged abuse on a specific date in 2017, that they had not reported it to the Director until one day later. [s. 24. (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 that ensures that a person who had reasonable grounds to suspect that abuse of a resident by anyone, or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, immediately reported the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.***



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**Issued on this 12th day of June, 2018**

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

**Original report signed by the inspector.**