Ontario

Ministry of Health and Long-Term Care	Ministère de la Santé et des Soins de longue durée
Inspection Report under the Long-Term Care Homes Act, 2007	**Rapport d'inspection prévue 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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 24, 2019	2019_624196_0022	016977-19	Complaint

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

LAUREN TENHUNEN (196)

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): September 9 - 13, 2019.

The following intake was inspected upon during this Complaint Inspection:
- one intake related to resident care concerns.

A Critical Incident System (CIS) inspection #2019_624196_0021 was conducted concurrently with this Complaint inspection

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), and a Nurse Practitioner (RN EC).

The Inspector also conducted a walk through of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed the home's complaint policy and procedure and complaint records.

The following Inspection Protocols were used during this inspection:
Reporting and Complaints

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

2 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 O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows: The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

A complaint was received by the Director that alleged improper care of residents at the home. In addition, the complainant indicated that verbal and written email complaints had been reported to the Administrator of the home without resolution.

A review of the home's policy titled, "Complaints and Customer Service" RC-09-04, last updated June 2019, indicated the Administrator or designate:
- "Ensure that timelines for responding to verbal/written complaint are followed and that the documentation is forwarded to provincial, regional, local health and/or other authorities, as required";
- "Initiate an investigation into the circumstances leading to the complaint within 24 hours. Investigation may include the following:....";
- "Complete the investigation within 10 days. If the investigation is not completed within 10 days, contact the complainant to indicate the investigation is ongoing and provide an estimated date of completion. Provide regular updates on the process until investigation is complete"; and
- "Provide written response at conclusion of investigation. Review draft with RD, and Communications where appropriate, prior to release. The written response will include: a. What the home has done to resolve the complaint. This will be shared with the

complainant/resident/SDM/family/staff or any other individuals involved., b. Depending on the severity of the complaint, a disclosure meeting may be required and the written response can be provided to the complainant at the meeting., c. If the complaint is unfounded, the reasons why this conclusion was reached...".

During an interview with the Administrator, Inspector #196 requested a copy of all written correspondence with the complainant. The Administrator provided a written document that had been addressed to the Medical Director which outlined resident care concerns and operational issues and a second email document that had been addressed to the Medical Director and the Administrator which outlined communication concerns with staff and resident care issues. The Administrator further reported that these had been provided to the Director of Care (DOC) for investigation.

During an interview with the DOC, they reported upon reviewing the documents, in the presence of the Administrator and the Inspector, that they had not investigated the complaints except to speak with the RN EC about one of the issues. In addition, they reported they had not followed up with the complainant and did not have investigation notes as the complaints had not been investigated.

During a further interview with the Administrator, they reported that they had not responded to the complainant in writing within ten days of receiving the written complaints, and had not investigated the complaints. [s. 101. (1) 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 every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately, to be implemented voluntarily.

WN #2: 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 when a written complaint concerning the care of a resident or the operation of the long-term care home was received, shall immediately forward it to the Director.

A complaint was received by the Director that alleged improper care of residents at the home. In addition, the complainant indicated that verbal and written email complaints had been reported to the Administrator of the home without resolution.

Inspector #196 reviewed the internal reporting system for the Ministry of Long-Term Care (MLTC) and records of these complaints could not be located.

A review of the home's policy titled, "Complaints and Customer Service" RC-09-04, last updated June 2019, indicated the Administrator or designate:
- "Where required by provincial, regional, local health and/or other authorities, forward a copy of the written complaint and response to the appropriate regulatory body"; and
- "Follow applicable provincial or other authority reporting requirements. Note: In Ontario, homes must forward a copy of the written complaint immediately to the Ministry of Health and Long-Term Care".

During an interview with the Administrator, Inspector #196 requested a copy of all written correspondence with the complainant. The Administrator provided a written document that had been addressed to the Medical Director which outlined resident care concerns and operational issues and a second email document that had been addressed to the Medical Director and the Administrator which outlined communication concerns with staff and resident care issues.

During a further interview with the Administrator, they reported that they had not submitted the written complaints to the Director. [s. 22. (1)]

Issued on this 25th day of September, 2019

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

Original report signed by the inspector.