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 25, 2019	2019_624196_0021	012848-19, 015742-19, 017497-19	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

LAUREN TENHUNEN (196)

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): September 9 - 13, 2019.

The following intakes were inspected upon during this Critical Incident System (CIS) Inspection:

- Two Logs related to resident falls with injury that resulted in a transfer to hospital; and
- one Log related to an incident of resident to resident abuse.

A Complaint inspection #2019_624196_0022 was conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nurse Practitioner (RN EC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Physiotherapist (PT), Physiotherapy Assistant (PTA), Personal Support Workers (PSWs), Resident Assessment Instrument (RAI) coordinator, Behavioural Support Ontario (BSO) staff member and residents.

The Inspector also conducted a 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, home's investigation records, Critical Incident System (CIS) reports, and applicable licensee policies, procedures and programs.

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

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

- **3 WN(s)**
- **3 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A Critical Incident System (CIS) report was received by the Director for an incident in which resident #001 sustained an injury and resulted in a significant change in the resident's health condition.

A review was conducted of resident #001's health care records. The Physiotherapy Assessment dated after the incident indicated the resident required a specific type of mobility device. A progress note written by RN EC (Nurse Practitioner) #103 on another date after the incident, indicated the residents status; the care that was to be provided; and the ability for the resident to use a specific type of mobility device. The current care plan identified a particular type of staff assistance with an activity of daily living, as a result of the injury and indicated a specific method of staff assistance with another activity.

During an interview, PSW #105 reported that resident #001 didn't perform a particular

activity of daily living and that a specific type of mobility device identified in the assessment, was not available. They further added that the resident wanted to perform this activity of daily living but there was no proper mobility device.

During interviews, RPN #106 reported resident #001 did not perform an activity of daily living until they were reassessed by the physiotherapist and RN #108 reported the resident was prescribed a particular level of activity.

During an interview, Physiotherapy Assistant (PTA)#107 reported that they thought this resident was being assisted by staff with an activity of daily living with a specific method of assistance.

During an interview with the Director of Care (DOC), they reported the resident had not performed an activity of daily living since the incident and was to maintain a certain level of activity.

During an interview, RN EC #103 reported that the resident had been provided with orders for symptoms and they were aware that the resident wanted to perform a particular activity of daily living. They further reported they were unaware that this resident had not been assisted with an activity of daily living, despite having written a progress note on a specific date, indicating they could be assisted using a specific type of mobility device.

During an interview with Physiotherapist (PT) #104, they reported that they had not provided an order for the resident to maintain a certain level of activity and had planned to reassess the resident's status at their next visit to the home. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the staff and others who provide direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

A Critical Incident System (CIS) report was received by the Director for an incident in which resident #001 sustained an injury and resulted in a significant change in the resident's health condition.

The current care plan for resident #001 identified a particular type of staff assistance with an activity of daily living, as a result of the injury and indicated a specific method of staff assistance with another activity.

During an interview with PSW #105, when asked for information regarding resident #001's required staff assistance with an activity of daily living, they reported that resident #001 did not perform a specific type of activity of daily living. When asked to show the Inspector the resident's care plan, the PSW was unable to access the care plan in the Point of Care (POC) tablet. They then reported their password didn't work and that the Inspector should ask a named PSW working on the other floor as they would be able to get it on the POC.

PSW #109 was asked by the Inspector and they were unable to log onto POC to locate the care plan and stated, "when I do their care, I know what they need".

PSW #110 was then asked if they could show the Inspector the care plans for any of their assigned residents and they said that they were able to chart in POC but didn't use the tablet to clarify the care that was needed, and was unable to show the care plan for residents.

During an interview with Resident Assessment Instrument (RAI) Coordinator #102, they reported that PSWs had access in their POC to view the care plans for the residents and they were no longer available in a paper copy. [s. 6. (8)]

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 staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other and ensures that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

In accordance with Ontario Regulation 79/10, s. 52. (1) 4., the licensee was required to ensure that the pain management program provided for the monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

Specifically, staff did not comply with the licensee's pain program policy titled, "Pain Identification and Management - RC-19-01-01", last updated August 2019. The policy read, "All residents will have a comprehensive pain assessment on admission and hospital readmission to the home (Appendix 1)" and "All residents will also have a comprehensive pain assessment completed with any new pain or new diagnosis of a painful disease, as per the procedures contained within this policy."

A Critical Incident System (CIS) report was received by the Director for an incident in which resident #001 sustained an injury and resulted in a significant change in the resident's health condition. The report further identified that the resident returned to the home later that date and that a specific intervention was not implemented.

On a date during the inspection, Inspector #196 was on a unit and overheard a resident yelling out. PSW #105 confirmed that this was resident #001 and that they had just assisted them with an activity of daily living; they were displaying symptoms when assisted and yelled out.

During an interview, RPN #106 reported that the resident was just administered a specific treatment as they were displaying a symptom.

The health care records for resident #001 were reviewed. A comprehensive pain assessment could not be located since the date of the resident's return from hospital on a specific date.

During an interview, RAI Coordinator #102 confirmed that resident #001 had not had a comprehensive pain assessment completed upon return from the hospital and this should have been completed.

During an interview with the Administrator, they reported that they had provided education to the staff to ensure a pain assessment was conducted upon resident #001's return from hospital and was disappointed to hear that this had not been completed. [s. 8. (1) (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 that ensures that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 39. Every licensee of a long-term care home shall ensure that mobility devices, including wheelchairs, walkers and canes, are available at all times to residents who require them on a short-term basis. O. Reg. 79/10, s. 39.

Findings/Faits saillants :

1. The licensee has failed to ensure that mobility devices, including wheelchairs, walkers and canes, were available at all times to residents who require them on a short-term basis.

A Critical Incident System (CIS) report was received by the Director for an incident in which resident #001 sustained an injury and resulted in a significant change in the

resident's health condition. The report further identified that the resident returned to the home later that date and that a specific intervention was not implemented.

During the course of the inspection, Inspector #196 observed resident #001 on five occurrences, at various times of the day.

During an interview, PSW #105 reported that resident #001 did not perform an activity of daily living that the resident wanted to do; and there was no specific type of mobility device to use.

During an interview, RN EC #103 reported that they were unaware that resident #001 had not been performing an activity of daily living with a specific assistive device despite having written a progress note that they could use a specific type of mobility device.

During an interview, PTA#107 reported that an application was awaiting consent from the substitute decision maker (SDM) for a government program for an assessment for a specific type of mobility device and that it could take between six and nine months to obtain this device.

During an interview, PT #104 reported they were waiting for consent for the government application to obtain a specific type of mobility device. They further added that the home should have had some similar mobility devices available to use as a loaner for the resident.

During an interview with the DOC, they reported they were not sure if a loaner mobility device could be obtained and thought the home did have some but they were currently used for other residents.

During an interview with the Administrator, they reported there was a specific type of mobility device and they had asked staff to get it for this resident. They further reported that they had asked staff to get this mobility device upon their return from hospital and they were disappointed this hadn't been done. [s. 39.]

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 mobility devices, including wheelchairs, walkers and canes, are available at all times to residents who require them on a short-term basis, to be implemented voluntarily.

Issued on this 27th day of September, 2019

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

Original report signed by the inspector.