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 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
Feb 15, 2019	2019_580568_0001	004991-17, 008243-17, 015557-17	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

Country Lane Long Term Care Residence
R. R. #3, 317079 Hwy 6 & 10 CHATSWORTH ON N0H 1G0

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

DOROTHY GINTHER (568)

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): January 16, 17, 18, 2019

Inspector #737 was present for this inspection.

The following Critical Incidents (CI) were inspected:
CI #1027-000001-17 log #004991-17; CI log 008243-17 related to responsive behaviours;
CI #1027-000003-17 log #015557-17 related to an unexpected death.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Office Manager, Programs Manager (PM), Registered Nurse (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and families.

The Inspectors also toured the home, observed dining, provision of resident care, staff interactions with residents and interactions between residents. They reviewed clinical records for identified residents as well as relevant policies and procedures.

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

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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004 was protected from abuse by anyone.

A Critical Incident (CI) was submitted the Ministry of Health and Long Term Care (MOHLTC) in relation to an altercation between two residents. The report identified that resident #003 had an altercation with resident #004 which resulted in resident #004 having sustained an injury.

Resident #003's plan of care identified that the resident exhibited identified responsive behaviours.

Progress notes on the day of the incident documented that resident #003 initiated the altercation which resulted in resident #004 having sustained an injury. The incident was reportedly unprovoked and un-witnessed.

RPN #104 stated that resident #003 had specified responsive behaviours. RPN #104 was not working on the date of the incident, but did recall that resident #004 sustained an injury as a result of an unwitnessed altercation with resident #003.

RN #103 said they were working on the day of the incident and recalled that there was an altercation between resident #003 and #004. As a result of this altercation resident #004 was injured.

The licensee has failed to ensure that resident #004 was protected from abuse by another resident. [s. 19. (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 to ensure that residents are protected from abuse by anyone and residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #2: 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 failed to immediately report a suspicion of abuse of a resident by another resident to the Director.

A CI report was submitted to the MOHLTC for an incident of alleged abuse which took place on a specified date.

Documentation in the progress notes indicated that the incident took place on a specified date. The CI report documentation, submitted seven days later, stated that the incident occurred one day after the progress note documentation.

During an interview with Administrator #101, they said that they were aware that any alleged or suspected incident of abuse must be immediately reported to the Director. They acknowledged that this incident was not reported immediately.

The licensee failed to immediately report an incident of alleged abuse of resident #004 by resident #003 to the Director. [s. 24. (1)]

Issued on this 15th day of February, 2019

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

Original report signed by the inspector.