Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jul 6, 2011	2011_092121_0010	Critical Incident

Licensee/Titulaire de permis

GROSVENOR HEALTH CARE PARTNERSHIP (NO. 3)
150 WATER STREET SOUTH, CAMBRIDGE, ON, N1R-3E2

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

ELIZABETH ELVIDGE (121)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with The Executive Director.

During the course of the inspection, the inspector(s) Reviewed the Critical Incident information, the Home's policy on Abuse/Neglect and the Prevention of Abuse, Neglect and Retaliation Inspection Protocol.

The following Inspection Protocols were used in part or in whole during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

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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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits sayants :

1. Jul 06, 2011 - 12:39 - The alleged abuse was reported to the Acting Executive Director on Sunday May 22/11. No call was made to the after hours pager.
The Critical Incident report was not submitted until May 25/11.

Issued on this 26th day of July, 2011

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

Elizabeth Kindyo