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 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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
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Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 16, 2017	2017_531518_0008	006081-17, 006119-17	Complaint

Licensee/Titulaire de permis

CVH (No. 5) GP Inc. as general partner of CVH (No. 5) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Country Village Homes - Woodslee
440 County Road 8 R. R. #2 Woodslee ON N0R 1V0

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

ALISON FALKINGHAM (518)

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): March 23 and 24, 2017.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care(DOC), the Assistant Director of Care(ADOC), two Registered Nurses(RN), two Registered Practical Nurses(RPN), two Personal Support Workers (PSW), the Programs Director and the internal Behavioural Support person(BS).

The inspector also reviewed three resident clinical records, the home`s policies and observed general staff to resident and resident to resident interactions.

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.
- **2 WN(s)**
- **1 VPC(s)**
- **1 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	Legendé 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 residents are protected from physical abuse by anyone and free from neglect by the licensee or the staff.

Under the Long-Term Care Homes Act, 2007, and Regulation 79/10, physical abuse was defined as:
(a) the use of physical force by anyone other than the resident that causes physical injury or pain,
(b) administering or withholding a drug for an inappropriate purpose, or
(c) the use of physical force by a resident that causes physical injury to another resident

The homes policy Zero Tolerance of Resident Abuse and Neglect Program RC-02-01-01 last revised April 2016 stated:
Abuse: in relation to a resident means physical, sexual, emotional, verbal or financial abuse.
Physical Abuse: the use of physical force by anyone other than a resident that causes physical injury or pain;administering or withholding a drug or an inappropriate purpose, or the use of physical force by a resident that causes physical injury to another resident.
Emotional Abuse: any threatening, insulting, intimidating or humiliating gestures, actions, behaviours, or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization, that are performs by anyone other than a resident, or any threatening or intimidating gestures, actions, behaviours or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour, or remarks understands and appreciates its consequences.

This inspection was conducted as a result of a complaint and Critical Incident System Incident which alleged resident to resident physical and verbal abuse resulting in injury.

A resident was admitted to the Long Term Care Home with multiple medical diagnosis and a cognitive performance scale (CPS) of 3/6.

An annual care conference was conducted with staff members and the Behavioural Support Ontario(BSO) team present, no family attended. The resident's behaviours were reviewed, a new medication was introduced and the team felt that the behaviours had improved at that time.

A pain assessment was completed on the resident to determine if pain could be the cause of these behaviours however the assessment indicated no pain.

The resident's most recent quarterly assessment showed the resident had deteriorated related to their dementia process and their short term memory problems. The resident

continued to have moderately impaired daily decision making skills.

A review of the resident's most recent plan of care documented goals and interventions for cognitive loss, psychological well being, adverse mood states and behavioural problems.

Review of the resident's clinical record showed thirteen incidents of abuse including injuries to residents over a specified period of time.

During an interview the resident stated to the inspector that they had trouble controlling their behaviour.

During the inspection a resident stated that they were fearful of the identified resident as were other residents in the home.

Interviews with Administrator, two DOC's, one RPN and three PSW's, all stated that multiple interventions had been tried.

The Administrator and DOC stated the behaviours displayed by the resident were unacceptable and were abusive in nature.

The licensee has failed to ensure that residents were protected from physical abuse by anyone.

The severity was determined to be a level three with actual harm to the residents. The scope of this issue was isolated. There was no compliance history of this legislation being issued in the home. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

An incident occurred that resulted in injuries to one resident.

The home's policy Risk Management:Emergency Care Managing a Head Injury CLIN-09-03-04K last revised December 2002 stated that staff were to assess for fractures, compare injured and uninjured sides and observe for swelling, bruising and pain.

Review of an identified resident's clinical record stated that vital signs had been taken and documented in the progress notes however the neurological assessment portion of the head injury routine was not completed or documented, no head to toe assessment was completed, no pain assessment had been completed and the physician was contacted however did not return the call immediately.

Interviews with Administrator, DOC and RN stated these assessments were not completed and the home's policies were not complied with.

The licensee has failed to ensure that Risk Management:Emergency Care Managing a Head Injury CLIN-09-03-04K was complied with.

The severity of this issue was determined to be a level three with actual risk of harm to the residents. The scope of this issue was isolated. There was a compliance history of this legislation being issued in the home on March 16, 2015 as a (Voluntary Plan of Correction(VPC) resulting from a Resident Quality Inspection 2015_349590_0008. [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 to ensure that any plan, policy, protocol, procedure, strategy or system otherwise put in place are complied with, to be implemented voluntarily.

Issued on this 13th day of July, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ALISON FALKINGHAM (518)
Inspection No. / No de l'inspection :	2017_531518_0008
Log No. / Registre no:	006081-17, 006119-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 16, 2017
Licensee / Titulaire de permis :	CVH (No. 5) GP Inc. as general partner of CVH (No. 5) LP c/o Southbridge Care Homes Inc., 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Country Village Homes - Woodslee 440 County Road 8, R. R. #2, Woodslee, ON, N0R-1V0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lenna Rombout

To CVH (No. 5) GP Inc. as general partner of CVH (No. 5) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The home shall prepare, submit and implement a plan to ensure that all residents will be protected from physical, emotional or verbal abuse by any resident or by anyone.
Please submit the plan in writing to,
Alison Spence-Falkingham, Long Term Care Homes Inspector, Ministry of Health and Long-Term Care, Long Term Care Homes Inspection Division, 130 Dufferin Avenue, 4th floor
London, ON, N6A 5R2, by email to alison.spence-falkingham@ontario.ca by June 30, 2017.

Grounds / Motifs :

1. . The licensee has failed to ensure that residents are protected from physical abuse by anyone and free from neglect by the licensee or the staff.

Under the Long-Term Care Homes Act, 2007, and Regulation 79/10, physical abuse was defined as:
(a) the use of physical force by anyone other than the resident that causes physical injury or pain,
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The licensee has failed to ensure that residents were protected from physical abuse by anyone.

The severity was determined to be a level three with actual harm to the residents. The scope of this issue was isolated. There was no compliance history of this legislation being issued in the home. [s. 19. (1)]

(518)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 14, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 16th day of June, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Alison Falkingham

Service Area Office /
Bureau régional de services : London Service Area Office