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
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 9, 2018	2017_532590_0022	016002-17	Resident Quality Inspection

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

ALICIA MARLATT (590), CAROLEE MILLINER (144)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 23 - 27, 2017.

A follow up inspection for log #015345-17 related to prevention of abuse and neglect, issued in Inspection #2017_531518_0008, with a compliance date of July 14, 2017, was completed within this Resident Quality Inspection (RQI).
An on-site inquiry for log #021347-17, IL-52758-LO was also completed for a complaint within this RQI.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Resident Programs Manager, one Registered Nurse (RN), eight Registered Practical Nurses (RPN), 12 Personal Support Workers (PSW), a representative of the Family Council, a representative of the Residents' Council, three family members and more than 20 residents.

During the course of the inspection, the inspector(s) observed the general maintenance and cleanliness of the home, postings of required information, the provision of resident care, resident and staff interactions, all resident home areas, medication administration, medication storage areas, infection prevention and control practices and recreational activities.

During the course of the inspection, the inspector(s) reviewed resident clinical records, Family Council meeting minutes, Residents' Council meeting minutes, relevant policies and procedures related to the inspection and Infoline reports.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2017_531518_0008	590

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for each resident set out clear directions to staff and others who provided direct care to the resident.

A) An identified resident was observed by inspectors on two specific days, using a safety device.

On review, the clinical record for this resident did not include the use of a safety device.

Two PSW's told Inspector #144 that the safety device was being used at the request of the resident.

A RPN told Inspector #144 that they were not aware that the identified resident used a safety device. The RPN acknowledged the safety device was not included in the plan of care for this resident.

The resident on interview, stated the safety device was being used at their request.

A RN stated that the safety device was not included in the plan of care for the identified resident.

The DOC stated that the safety device should have been included in the plan of care for the identified resident and that the plan of care had not provided clear direction to staff.

B) An identified resident was observed by Inspectors on two specific days, using a potential Personal Assistance Services Device (PASD) that had potential restraining effects.

The clinical record for the identified resident was reviewed by Inspector #144 and did not include the use of the identified potential PASD.

A PSW told Inspector #144 that the identified device for the resident was used and monitored as a restraint. The PSW said that the resident was not regularly monitored by PSW staff when the restraint was used.

A RPN told the Inspector that they were not aware the resident used the identified potential PASD. The RPN reviewed the clinical record for the resident and said that

alternatives to the use of a physical restraint assessment had not been completed, there was not a physician's order for the resident to utilize the identified potential PASD, and that a signed consent from the residents' substitute decision-maker had not been obtained. The RPN acknowledged that the plan of care for this resident did not include use of the potential PASD.

The DOC said that the plan of care for the identified resident should have included the use of the potential PASD and that they weren't certain if the identified device had been used as a restraint or to facilitate an Activity of Daily Living (ADL) for the resident.

The licensee has failed to ensure the plan of care for an identified resident set out clear directions to staff and others who provided care to the resident.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of the inspection. The home has a compliance history of this legislation being issued in a Resident Quality Inspection #2016_243634_0017 as a Voluntary Plan of Correction on September 28, 2016. [s. 6. (1) (c)]

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 the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

In stage one of this Resident Quality Inspection during a staff interview with a RAI Coordinator, the staff member shared that an identified resident had fallen on a specified date.

Review of this resident's completed assessments showed that a post-fall assessment had not been completed after the fall on the identified date.

In an interview with a RPN, they shared that when a resident falls, registered staff were to initiate a risk management report in Point Click Care (PCC) that triggered a post-fall assessment to also be completed by registered staff in PCC as soon as possible after the fall.

The home's policy titled Falls Prevention and Management Program, policy number RC-15-01-01, last updated in February 2017, stated in the post-fall management procedure section two, that staff were to "Hold a Post-Fall Huddle, ideally within the hour and complete a post-fall assessment as soon as possible. See Post Fall Assessment Tool, Appendix 11 and Post-Fall Team Huddle Process, Appendix 12."

In an interview with the DOC, they shared that they also could not locate a completed post-fall assessment for the identified residents fall which occured on the specific date, and said that one should have been completed.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of the inspection. The home has a compliance history of this legislation being issued in a Complaint Inspection #2017_419658_0009 as a Voluntary Plan of Correction on June 28, 2017. [s. 49. (2)]

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 when a resident has fallen, the resident is assessed and, if required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 9th day of January, 2018

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

Original report signed by the inspector.