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
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
Facsimile: (519) 675-7685

Bureau régional de services de London
291, rue King, 4iém étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685

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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
Sep 20, 21, 22, 26, Nov 16, 2011	2011_093145_0016	Complaint

Licensee/Titulaire de permis

GROSVENOR HEALTH CARE PARTNERSHIP (NO. 4)
150 WATER STREET SOUTH, CAMBRIDGE, ON, N1R-3E2

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

COUNTRY VILLAGE HEALTH CARE CENTRE
440 County Road 8, R. R. #2, Woodslee, ON, N0R-1V0

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

KARIN MUSSART (145)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with The Administrator and the Environmental Services Manager.

During the course of the inspection, the inspector(s) Reviewed the maintenance policy and procedures; reviewed work order for corrective action.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Critical Incident Response

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding.

2. An unexpected or sudden death, including a death resulting from an accident or suicide.

3. A resident who is missing for three hours or more.

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.

2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.

3. A missing or unaccounted for controlled substance.

4. An injury in respect of which a person is taken to hospital.

5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. Home did not advise the Director after a break-down of the elevator. No Critical Incident Report made.
[O.Reg. 79/10, s.107,(3) 2.]
2. A Critical Incident report was not filed for the loss of use of the elevator on July 31/11. No communication was received from the home in response to this incident.
[O.Reg. 79/10, s.107,(1) 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 critical incidents are reported as per the legislative requirement., to be implemented voluntarily.

Issued on this 16th day of November, 2011

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