Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée


**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Mar 17, 2022 | 2022_791739_0011 | 001288-22, 001351-22, 002430-22 | Critical Incident System |

### Licensee/Titulaire de permis

CVH (No. 5) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
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 Village Homes - Woodslee
440 County Road 8, R.R. #2 South Woodslee ON N0R 1V0

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

JULIE DALESSANDRO (739)

## 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): March 4, 7, 9, 10, 14, and 15, 2022.**

**During the course of this inspection the following intakes were completed:**
**Log #001288-22/CI #2576-000002-22 related to alleged abuse**
**Log #001351-22/CI #2576-000003-22 and Log #002430-22/CI #2576-000005-22 related to falls prevention and management**

**During the course of the inspection, the inspector(s) spoke with Housekeeper(s), Personal Support Worker(s), Registered Practical Nurse(s), Registered Nurse(s), and the Associate Director of Care.**

**During the course of this inspection the inspector(s) also conducted observations and record review relevant to the inspection.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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:**

**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, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.**

**Findings/Faits saillants :**

The licensee had failed to ensure that an alleged abuse between two residents, which resulted in risk of harm, was immediately reported to the Director.

A Critical Incident System (CIS) Report was submitted to the Ministry of Long-Term Care. The CIS report indicated that there was alleged abuse that had occurred between two residents and it was not reported to the Director until three days after the incident.

A progress note in one resident's chart indicated that the incident of alleged abuse was witnessed but not reported until three days later and the other resident appeared uncomfortable after the incident.

During an interview with a PSW they stated that they made a Registered Practical Nurse (RPN) aware of the incident two hours after it happened.

During an interview with a Registered Nurse (RN) they stated that the RPN had not informed them of the incident until three days after it occurred and it should have been reported right away.

During an interview with the Associate Director of Care (ADOC) they stated that, the RPN should have reported the incident between the two residents to the RN right away. The ADOC acknowledged that this incident of alleged abuse should have been reported to the Director on the date that it occurred.

Not immediately reporting the alleged abuse to the Director posed minimum risk to the resident.

Sources: CI, Resident’s progress note, interviews with a PSW, RN, and ADOC.

***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 alleged abuse is immediately reported to the Director., to be implemented voluntarily.***

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**Issued on this 18th day of March, 2022**

[redacted]

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

**Original report signed by the inspector.**