Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: August 1, 2024

Inspection Number: 2024-1091-0002

Inspection Type:
Complaint
Critical Incident

Licensee: CVH (No. 5) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)

Long Term Care Home and City: Country Village Homes - Woodslee, South Woodslee

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 9, 10, 11, 12, 15, 16, 2024

The following intake(s) were inspected:

- Intake: #00116531 - Critical Incident: #2576-000018-24 - Improper/Incompetent treatment of a resident.
- Intake: #00117029 - Critical Incident: #2576-000020-24 - Alleged neglect to a resident.
- Intake: #00119954 - Critical Incident: # 2576-000026-24 - Related to falls prevention and management for a resident.
- Intake: #00120457 - Critical Incident: #2576-000028-24 - Alleged neglect to a resident.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied with for a resident.

Rationale and Summary:
A Critical Incident System (CIS) report was submitted to the Director, as a result of alleged staff to resident abuse. According to the CIS report, a resident reported the incident to staff. The resident was not assessed by the registered staff following the resident's allegation of abuse.

During the interview with a Registered Nurse (RN) they stated that the resident

brought forward an allegation of abuse on a specific date. Review of the resident's clinical records in Point Click Care (PCC), the inspector was unable to find progress notes or a post incident assessment of the resident following the allegation.

Review of Country Village's "**Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct":** policy, last reviewed August 2023, stated that with any allegation of abuse the registered staff are to ensure the safety of and provide support to the abuse victim(s), through completion of full assessments, a determination of resident needs and a documented plan to meet those needs.

The Administrator, Assistant Director of Care (ADOC), and Interim Director of Care (IDOC) acknowledged that the resident should have been assessed using a Head-to-toe assessment in Point Click Care following the reported allegation.

There was a risk to the resident when allegations of physical abuse were not immediately assessed per the home's policy.

Sources: Critical incident; interviews with the Administrator, ADOC, and IDOC; resident's clinical records, investigation notes provided by the home.

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director

s. 28 (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.

The licensee has failed to ensure that the alleged improper/incompetent care to a resident was immediately reported immediately to the Director.

Rationale and Summary:
A Critical Incident System (CIS) report was submitted to the Director, as a result of alleged staff to resident abuse. According to the CIS report, a resident reported the incident. The homes former DOC interviewed staff and stated that the resident reported the alleged abuse and pain to a staff member on a specific date. The former DOC was not able to locate reports completed on that date.

The Administrator, the Assistant Director of Care (ADOC), and Interim Director of Care (IDOC) acknowledged that the alleged improper/incompetent care was reported late.

The purpose of immediate reporting is to ensure the appropriate action is taken to such an event, the home failing to report immediately to the Director leaves the resident at risk.

Sources: Review of the critical incident; interview with the Administrator, ADOC, and IDOC.

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