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

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
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 # / Registre no	Type of Inspection / Genre d'inspection
Jun 17, 2015	2015_226192_0040	008752-15	Complaint

Licensee/Titulaire de permis

CVH (No.2) LP
c/o Southbridge Care Homes 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

COUNTRY LANE LONG TERM CARE RESIDENCE
R. R. #3, 317079 HWY 6 & 10 CHATSWORTH ON N0H 1G0

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

DEBORA SAVILLE (192)

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): May 28 and 29, 2015

This complaint inspection was conducted in relation to resident assessment with a change in condition, the medical program in the home, nutrition and hydration, continence care and pain.

This inspection was conducted on May 28 and 29, 2015 and information gathered was entered onto an electronic version of the Inspection Protocols. When the Inspector Quality Solution was available, information gathered during the inspection was copied into the Inspector Quality Inspection tool and the Inspection Reports were generated.

During the course of the inspection, the inspector(s) spoke with the Administrator, Registered Nurse, Registered Practical Nurses, Personal Support Workers, Dietary Aides and residents.

The inspector toured the home, observed meal and snack service, reviewed Medical Records and Policy and Procedure.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Nutrition and Hydration
Pain
Responsive Behaviours
Sufficient Staffing

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 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with their needs was respected and promoted.

A) Resident #001 had monthly vital signs taken on a specified date in 2015 that identified that the resident's arterial oxygen saturation (SaO2) was lower than the home's established threshold of 94 percent and the recorded SaO2 was flagged in the Point Click Care record.

Interview with a Registered Nurse confirmed that it would be the expectation of the home, that if an SaO2 reading of less than 94 percent was obtained a chest assessment would be completed for the resident and the SaO2 result would be rechecked. Interview confirmed that no chest assessment was completed for resident #001.

B) Six days later, documentation indicated that the resident was complaining of not being able to stand and having dry lips. Vital signs were taken and identified an SaO2 below the home's threshold on room air.

Interview with the registered nurse confirmed that no chest assessment was completed at this time.

C) Two weeks later, documentation indicated that resident #001 complained of pain that had started the previous evening, was described as sharp and was coming and going. Vital signs taken at the time indicated that the resident's SaO2 was below the home's specified threshold.

Interview with the registered nurse confirmed that no chest assessment was completed at this time.

D) The following day, staff of the home were approached by a visitor to the home, who expressed concern for the status of resident #001. Documentation indicated that, at this time, the resident had an SaO2 reading below the home's threshold and presented with pain, their coloring was pale and edema was present. The resident was sent to hospital where they were diagnosed with an acute condition.

Interview with the registered nurse confirmed that there was no recorded assessment of the residents respiratory system.

E) Review of the medical record identified that during a specified month in 2015, resident #001 had an increased frequency of a specified behaviour. Review of the medication administration record identified that it was unusual for resident #001 to require as necessary medication. During the specified month in 2015 resident #001 received as necessary medication on multiple occasions.

Interview with the Administrator confirmed that resident #001 had specified behaviours that had exacerbated through the specified month, and that the resident had as necessary medication more frequently in relation to these behaviours.

The licensee failed to ensure that resident #001 was cared for in a manner consistent with their needs when they sustained a change in condition, and were not assessed.[s. 3. (1) 4.]

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 ensuring that every resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with their needs is respected and promoted, to be implemented voluntarily.

Issued on this 18th day of June, 2015

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

Original report signed by the inspector.