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

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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
Nov 30, 2017	2017_448155_0022	025907-17	Resident Quality Inspection

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

SHARON PERRY (155), ADAM CANN (634)

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): November 20, 21, 22, 23, 24, 27 and 28, 2017.

The following intakes were completed within the Resident Quality Inspection:
-Log 031112-16 -follow up inspection regarding compliance order #001, inspection 2016_448155_0014 related to ensuring that there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present in the home at all times;
-Log 022213-17 related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, Office Manager, Recreation Services Manager, Nurse Consultant, three Registered Nurses, two Registered Practical Nurses, three Personal Support Workers, Family Council representative, Resident Council representative, families and residents.

The inspectors also toured the home, observed medication administration, medication storage; reviewed relevant clinical records, meeting minutes, schedules, posting of required information; observed the provision of resident care, resident and staff interactions, and observed the general maintenance, cleanliness, safety and condition of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Residents' Council
Skin and Wound Care
Sufficient Staffing

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

2 WN(s)
0 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. 8. (3)	CO #001	2016_448155_0014	155

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 O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

On November 23, 3017, a Personal Support Worker was observed entering the utility room using a key that was hanging on the utility room door. When the door opened a one-litre bottle of Blue Force gel bowl cleaner and a bottle of Wood Wyant everyday disinfectant cleaner was observed sitting on the shelf just inside the door.

On November 23, 2017 the Administrator/Director of Care and Nurse Consultant were informed that there were hazardous substances in the utility room that were accessible to residents. They immediately shared that the cleaner and disinfectant could not be kept there and the Administrator/Director of Care removed the cleaner and disinfectant from the utility room and placed it in a room that was not accessible to residents.

The licensee failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm (level 2), the scope was isolated (level 1) and there was unrelated non-compliance issued in the last three years (level 2). [s. 91.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that when they were required to inform the Director of an incident under subsection (1), (3) or (3.1) they shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the outcome or current status of the individuals who were involved in the incident.

A Critical Incident System report was submitted to the Ministry of Health and Long Term Care. An amendment was requested by the Director to be submitted by the licensee, which was requesting the outcome or current status of the individuals who were involved in the incident.

Interview was completed with Director of Care/ Administrator who stated they did not amend the Critical Incident System report as requested by the Director and should have.

During this inspection this non-compliance was found to have a severity level of minimum risk (level 1), the scope was isolated (level 1), and there was unrelated non-compliance issued in the last three years (level 2). [s. 107. (4)]

Issued on this 30th day of November, 2017

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

Original report signed by the inspector.