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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 23, 2018	2018_533115_0024	012834-17, 019962-17, 020888-17, 021179-17, 007722-18, 008475-18, 010624-18, 018237-18	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 5) GP Inc. as general partner of CVH (No. 5) LP
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 Woodslee ON N0R 1V0

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

TERRI DALY (115), DEBRA CHURCHER (670)

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): This inspection was conducted on the following date(s): November 5, 6, 7, 8, 9, 13, 14, 15, and 16, 2018

Inspector #739 and Inspector #731 participated in this critical incident inspection.

The following Critical Incident inspections were conducted:
Related to falls prevention:
Critical Incident Log #010624-18 / 2576-000005-18;
Critical Incident Log #018237-18 / 2576-000008-18;
Critical Incident Log #007722-18 / 2576-000003-18.

Related to prevention of abuse and neglect:
Critical Incident Log #012834-17 / 2576-000008-17;
Critical Incident Log #019962-17 / 2576-000010-17;
Critical Incident Log #020888-17 / 2576-000011-17;
Critical Incident Log #021179-17 / 2576-000012-17;
Critical Incident Log #008475-18 / 2576-000004-18.

During the course of the inspection, the inspector(s) spoke with the Long Term Care Executive Director (ED), the Director of Care (DOC), one Registered Nurse (RN), three Registered Practical Nurses (RPN), one Registered Practical Nurse/ Behaviour Support Ontario team member, a Housekeeping Aide, seven Personal Support Workers (PSW), and residents.

The inspectors also observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home and internal investigative notes.

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

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

- **3 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	Légende 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The home submitted a Critical Incident System report (CIS) to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, related to a resident to resident incident.

Review of the submitted CIS and the clinical records of resident #006 and #007 showed an incident between the two residents on a specific date. This incident was witnessed by staff.

Review of resident #006's current care plan stated that there was to be a specific intervention in place.

Observation of resident #006's room on three separate dates showed that the intervention was not in place.

During an interview with DOC #101 they stated that the specific intervention should have been in place for this resident and acknowledged that the plan of care was not followed.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

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 care specified in the plan of care is provided to the resident, to be implemented voluntarily.

WN #2: 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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that 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 was 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 or the Local Health System Integration Act, 2006.

The home submitted a Critical Incident System report (CIS) to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, related to a resident to resident incident.

Review of the submitted CIS and the clinical records of resident #004 and #005 showed that an incident had occurred between the two residents on a specific date. Resident #005 sustained an injury as a result of the incident.

Review of the submitted CIS showed that the incident occurred on a specific date, and the CIS report was not submitted to the Director until two days after.

Director of Care (DOC) #101 stated the staff should have called the MOHLTC action line the date of the incident. [s. 24. (1)]

2. The home submitted a Critical Incident System report (CIS) to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, related to a resident to resident incident.

Review of the submitted CIS and the clinical records of resident #006 and #007 showed that an incident had occurred between the two residents on a specific date. This incident was witnessed by staff.

Review of the submitted CIS showed that the incident occurred on a specific date, and the CIS report was not submitted until the day after.

The home's policy titled, Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, last updated April 2017, stated; procedures, Director of Care follow province specific reporting requirements.

Director of Care (DOC) #101 stated the staff should have called the MOHLTC action line or completed a CIS on the date of the incident.

The licensee has failed to ensure that a person who has reasonable grounds to suspect that 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 resident has occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence.

The home submitted a Critical Incident System report (CIS) to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, related to a resident to resident incident.

Review of the submitted CIS and the clinical records of resident #004 and #005 showed that an incident had occurred between the two residents. Resident #005 sustained an injury as a result of the incident.

Review of the submitted CIS showed that the police had not been notified.

Director of Care (DOC) #101 stated that the practice in the home was to allow the family members to decide if the police were to be notified or not and that resident #005's family did not want the police notified about this incident. DOC #101 acknowledged that the police should have been notified. [s. 98.]

2. The home submitted a Critical Incident System report (CIS) to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, related to a resident to resident incident.

Review of the submitted CIS and the clinical records of resident #006 and #007 showed that an incident had occurred between the two residents. This incident was witnessed by staff.

Review of the submitted CIS showed that the police were not notified.

The home's policy titled, Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, last updated April 2017, stated; procedures, Director of Care, notify police authorities, as per jurisdictional and legislative requirements, as applicable.

Director of Care (DOC) #101 stated that the practice in the home was to allow the family members to decide if the police were to be notified or not and that from their recollection neither of the resident's families wanted the police notified about this incident. DOC #101 acknowledged that the police should have been notified.

The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence. [s. 98.]

Issued on this 23rd day of November, 2018

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

Original report signed by the inspector.