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 # / Registre no	Type of Inspection / Genre d'inspection
Aug 25, 2016	2016_229213_0025	016308-15	Critical Incident System

Licensee/Titulaire de permis

CVH (No.3) GP Inc. as general partner of CVH (no.3) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Chelsey Park
310 OXFORD STREET WEST LONDON ON N6H 4N6

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

RHONDA KUKOLY (213), ADAM CANN (634), SHERRI COOK (633)

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): August 2, 3, 4, 5, 2016

This inspection was completed related to several critical incidents:
Log #016308-15, Critical Incident #2655-000047-15 related to improper or incompetent treatment of a resident resulting in harm or risk of harm to a resident.
Log #022679-15, Critical Incident #2655-000055-15 related to a resident report of missing money.

Log #027522-15, Critical Incident #2655-000063-15 related to a resident report of missing money.
Log #001130-16, Critical Incident #2655-000002-16 related to a resident report of missing money.
Log #008981-16, Critical Incident #2655-000027-16 related to alleged staff to resident abuse.
Log #009976-16, Critical Incident #2655-000033-16 related to alleged staff to resident abuse.
Log #019882-16, Critical Incident #2655-000051-16 related to alleged staff to resident abuse.
Log #020010-16, Critical Incident #2655-000053-16 related to alleged staff to resident abuse.
Log #009603-16, Critical Incident #2655-000030-16 related to a complaint regarding resident charges.

This inspection was completed while in the home completing other complaint inspections which can be found in separate reports. A finding of non-compliance related to not complying with the home's Complaints and Customer Service Policy found in complaint inspections log #017157-16 & #017467-16, Inspection #2016_229213_0027 completed by Inspector #213 and log #027364-15, Inspection #2016_255633_0012, completed by Inspector #633, have been issued in this critical incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Clinical Educator, the Director of Environmental Services, a Clinical Nurse Coordinator, the Admission Coordinator, an Assistant Director of Care, four Registered Nurses, seven Registered Practical Nurses, nine Personal Support Workers, a Housekeeping Aide, a Dietary Aide, a Receptionist, an Administrative Assistant, thirteen residents and a family member.

The inspectors also made observations, and reviewed health records, education records, policies and procedures, and other relevant documentation.

The following Inspection Protocols were used during this inspection:

Dining Observation
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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

- **4 WN(s)**
- **3 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Complaints and Customer Service policy was complied with.

The home's "Complaints and Customer Service" policy #RC-11-01-04 indicated:
"Procedure: Complete a concern/complaint investigation form in detail and forward to the Administrator.
Continuous Quality Improvement: Maintain a record of all complaints and actions taken in the Complaint Log. Retain written investigation records and keep them in one location".

a) The home reported a critical incident regarding a resident concern related to missing money from resident #012. There was no complaint form or documentation of the complaint or action taken for resident #012 in the home's complaint binder related to missing money from resident #012.

b) In an interview with Registered Nurse (RN) #126 on August 5, 2016, the RN shared that she received a concern from the family of resident #013 related to care issues and missing personal items. The RN said that they completed the initial stages of a complaint form and forwarded it to the Director of Care (DOC) #102. In an interview with the DOC #102 on August 5, 2016, she shared that she did not have the complaint form related to resident #013, it was not in the complaints binder and did not know what happened to it. There was no complaint form or documentation of the complaint or action taken for resident #013 in the home's complaint binder related to care concerns or missing personal items.

c) The home reported in critical incident #2655-000063-15, that the family of resident #014 submitted a complaint via email related to being billed for services that were not provided. Record review of the home's complaints binder revealed no record of the complaint related to billing for services for resident #014.

d) The home reported in a critical incident on October 1, 2015 related to a resident to resident altercation involving resident #015 and #007. In an interview with the Administrator #102 and the Director of Care #101 on August 2 and 4, 2016, they shared that they were aware of a complaint from the family of resident #015 and a complaint form had been completed, but it had been kept in a separate location and not in the complaint binder. There was no complaint form or documentation of the complaint or action taken for resident #007 in the 2015 complaint binder related to a resident to

resident altercation.

In an interview with the Administrator #101 and the Director of Care #102 on August 5, 2016, they both agreed that there were no complaint forms that could be found related to:

- resident #012 related to missing money
- resident #013 related to numerous care issues, missing personal items, etc.
- resident #014 related to billing
- resident #015 related to a resident to resident altercation

In an interview on August 5, 2016, the Administrator #102 and the Director of Care #101 said that the expectation was that residents and families themselves, staff on the unit who receive a complaint, or management staff start yellow complaint forms when they received complaints. They shared that the complaints were to go to the appropriate manager for appropriate follow up and action, the completed forms were to be kept in the complaint binder as the Administrator reviewed the complaint forms in the complaint binder quarterly for analysis of trends. They said that the complaints that were not in the complaints binder were not included in the quarterly analysis.

The home did not comply with their Complaints and Customer Service policy for residents #012, #013, #014 or #015 when complaint forms were not completed or kept in the home's complaint binder. [s. 8. (1) (b)]

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 the Complaints and Customer Service policy is complied with, 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 the person who had reasonable grounds to suspect that abuse had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

Record review was completed of progress notes in Point Click Care for resident #003. On a specified date, resident #003 made an allegation of staff to resident physical abuse to Registered Practical Nurse (RPN) #131 which allegedly occurred on the previous day.

Record review was completed of the critical incident report #2655-000027-16, submitted to the Director by the home five days following the resident's report. The critical incident report said that the suspected abuse occurred on a specified date.

Interview was conducted with Director of Resident Care #101 on August 17, 2016. She said the allegation of staff to resident physical abuse occurred on a specified date but was not reported to the Director until five days later. She said she was made aware of the allegation two days prior to reporting it. She said that the incident should have been reported immediately to the Director. [s. 24. (1)]

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 a person who has reasonable grounds to suspect that abuse has occurred or may occur, immediately reports the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
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. 104 (1).

Findings/Faits saillants :

1. In making a report to the Director under subsection 23 (2) of the Act, the licensee has failed to include the follow-up action, including, the immediate actions that have been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence.

The home submitted a critical incident #2655-000047-15, regarding an incident that occurred on on a specified date involving resident #001 who suffered an injury of unknown cause on the same date.

The critical incident was not updated to include the follow-up action, including, the immediate actions that have been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence. The critical incident was last updated on a specified date indicating "ongoing investigation continues with the interviewing of all staff to determine how and when the injury occurred", and "a further analysis of the event will be forthcoming tomorrow". No further information was included in the critical incident including the analysis or actions taken.

In an interview with the Director of Care (DOC) on August 2, 2016, the DOC said that she wasn't aware that the critical incident was not updated and that it should have been amended following the investigation with the outcome of the investigation and actions taken.

The home failed to include the outcome of the investigation and follow-up actions taken related to the critical incident submitted related to resident #001. [s. 104. (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 to ensure that when making a report to the Director under subsection 23 (2) of the Act, the licensee includes the follow-up action, including, the immediate actions that have been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 233. Retention of resident records

Specifically failed to comply with the following:

s. 233. (2) A record kept under subsection (1) must be kept at the home for at least the first year after the resident is discharged from the home. O. Reg. 79/10, s. 233 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a record kept was kept at the home for at least the first year after a resident was discharged from the home.

Resident #001 was discharged from the home on a specified date. An incident occurred involving the resident on a specified date The home completed an investigation and took appropriate actions.

In interviews with the Director of Care (DOC) and the Administrator on August 2 and 3, 2016, they said that they did not have any of the investigation records or follow up actions related to the incident that occurred. No assessments, incident reports, investigation notes, staff interviews or staff follow up actions were in the home at the time of the inspection. The DOC and Administrator said that the records related to the incident involving resident #001 must have been destroyed.

The home failed to keep a record related to an incident involving resident #001 at the home for at least the first year after the resident was discharged from the home. [s. 233. (2)]

Issued on this 25th day of August, 2016

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

Original report signed by the inspector.