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 |
|---|---|---|---|
| Sep 13, 2016 | 2016_229213_0030 | 026022-16 | Resident Quality Inspection |

## 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), ALICIA MARLATT (590), ANN POGUE (636), NATALIE MORONEY (610)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): August 29, 30, 31, September 1, 2, 6, 7, 8, 9, 2016**

**The following critical incidents were inspected concurrently within this RQI:**
**Log #022169-15 Critical incident #2655-000054-15 related to responsive behaviours**
**Log #001681-16 Critical incident #2655-000005-16/2655-000006-16 related to falls**

**Log #005666-16 Critical incident #2655-000014-16 related to injury of unknown origin**
**Log #006379-16 Critical incident #2655-000003-16 related to falls**
**Log #032710-16 Critical incident #2655-000079-15 related to alleged staff to resident abuse**
**Log #010314-16 Critical incident #2655-000035-16 related to call bell not working**
**Log #018936-16 Critical incident #2655-000015-16 related to falls**
**Log #026575-15 Critical incident #2655-000058-15 related to a flood**
**Log #022573-16 Critical incident #2655-000058-16 related to falls**
**Log #024603-16 Critical incident #2655-000065-16 related to falls**
**Log #025744-16 Critical incident #2655-000068-16 related to alleged staff to resident abuse**
**Log #014103-16 Critical incident #2655-000042-16 related to call bells not working**
**Log #027523-16 Critical incident #2655-000072-15 related to falls**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing Care, the Food Services Supervisor, the Housekeeping/Laundry & Safety Manager, the Staff Educator, the Resident Assessment Instrument (RAI) Coordinator, the Office Manager, a Contracted Maintenance Supplier, two Nursing Operations Supervisors, two Registered Dietitians, four Registered Nurses, 13 Registered Practical Nurses, 11 Personal Support Workers, a Nursing Administration Clerk, a Receptionist, a Recreation Aide, a Dietary Aide, a Maintenance Staff, a Housekeeping Aide, a Laundry Aide, five family members and over 40 residents.**

**The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meal and snack service, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry of Health and Long-Term Care information and inspection reports and the general maintenance, cleaning and condition of the home.**

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

**Accommodation Services - Laundry**
**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Residents' Council**

**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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (9) The licensee shall ensure that the following are documented:**
**1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Resident #062 was identified as a high nutritional risk in two assessments.The resident was to receive a nutritional supplement daily.

Review of the Nutritional Intake Record for a period of three months revealed the following missing documentation:
An identified month was missing 12 of 30 days or 40% of required entries.
A second identified month was missing 7 of 31 days or 23% of required entries.
A third identified month was missing 4 of 31 days or 13% of required entries.

In an interview with Registered Dietitian #116 on September 2, 2016, she confirmed that incomplete documentation on the Nutrition Intake Records could have resulted in her not having appropriate information to complete an accurate assessment of resident #062.

In an interview with Director of Care #102 on September 6, 2016, she confirmed that the home expected supplement administration to be documented on the Nutritional Intake Records by staff after they are administered.

The provision of nutritional supplements were not documented as set out in the plan of care for resident #062. [s. 6. (9) 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 the provision of the care set out in the plan of care is documented, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

**Specifically failed to comply with the following:**

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**19. Safety risks. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The license has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of safety risk with respect to the resident.

An incident occurred and resident #024 had a significant change in status. Progress notes indicated resident #024 exhibited responsive behaviours during a specified period of time that were a safety risk.

Resident #024 was not reassessed and the care plan was not updated to indicate that resident's personal safety was at high risk related to specified responsive behaviours with appropriate interventions until approximately one month after the behaviour was first identified.

On September 1, 2016, the Director of Care (DOC) #102 said that resident #024 did exhibit the identified responsive behaviour and that this was a safety risk. She indicated a specified intervention as an expectation and that it had not been implemented prior to the care plan being updated.

On September 8, 2016, the Administrator #101 acknowledge that resident #024 should have been assessed and the plan of care updated when the home became aware of the safety risk . [s. 26. (3) 19.]

***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 plan of care is based on, at a minimum, interdisciplinary assessment of safety risk with respect to the residents, 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**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that was reported to the licensee, was immediately investigated, appropriate action was taken in response to every such incident, and any requirements that were provided for in the regulations for investigating and responding as required under clauses (a) and (b) were complied with. The licensee also has failed to report to the Director the results of every investigation undertaken under clause (1) (a) and included all material provided for under the regulations.

A critical incident indicated that resident #006 reported alleged staff to resident abuse.

In an interview with the Director of Care (DOC) #102 and the Administrator #101 on September 8, 2016, the DOC said that she believes that investigation related to the critical incident involving resident #006 showed the accusation was unfounded and that staff and residents were interviewed. Neither the DOC or the Administrator were able to recall the details of the investigation, if the resident and/or substitute decision maker (SDM) were notified of the results of the investigation or if they were satisfied with the home's follow up. The Administrator and DOC were not able to produce any documentation of the home's investigation or what follow up had occurred. They also agreed that the critical incident had not been updated to include the results of the investigation, the analysis of the occurrence, the actions taken in response or to prevent reoccurrence, or what had been communicated with the resident and/or SDM.

An alleged incident of staff to resident abuse reported by resident #006 was not immediately investigated, appropriate action was not taken and results were not reported to the Director. [s. 104.]

***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 every alleged, suspected or witnessed incident of abuse of a resident by anyone that was reported to the licensee, was immediately investigated, appropriate action was taken in response to every such incident, and any requirements that were provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. The licensee will also ensure to report to the Director the results of every investigation undertaken under clause (1) (a) and include all material provided for under the regulations, to be implemented voluntarily.***

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**WN #4: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was implemented in accordance with all applicable requirements under the Act, and complied with.

a) The home had a policy regarding posting signs to alert staff of infection control practices.

Observations related to resident #027 revealed the identified infection control policy was not followed for resident #027.

On September 7, 2016, at 1325 hours, the Director of Care #102 agreed that the identified infection control policy was not followed for resident #027.

b) The home had a policy regarding screening and infection control practices.

Record reviews related to resident #021 revealed the identified infection control policy was not followed for resident #021.

On September 6, 2016, the Nursing Operations Supervisor #130 agreed that the identified infection control policy was not followed for resident #021.

The home did not comply with the home's infection prevention and control policies for resident #021 or resident #027. [s. 8. (1)]

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**Issued on this 13th day of September, 2016**

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

**Original report signed by the inspector.**