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
Jun 20, 2017	2017_262630_0016	006377-16, 035480-16, 008438-17, 008765-17	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

AMIE GIBBS-WARD (630)

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): June 5, 6, 7, 8, 9 and 12, 2017.

The following Critical Incident (CI) inspection was conducted:

Related to falls prevention:
Critical Incident Log #006377-16 / CI 2655-000004-16;

Critical Incident Log #035480-16 / CI 2655-000148-16;
Critical Incident Log #008765-17 / CI 2655-000042-17;
Critical Incident Log #008438-17 / CI 2655-000041-17.

The following intakes were inspected at the same time as this Critical Incident inspection and can be found in separate reports:

Related to prevention of abuse and neglect:
Critical Incident Log #012810-16 / CI 2655-000040-16;
Critical Incident Log #015296-16 / CI 2655-000044-16;
Critical Incident Log #008908-17 / CI 2655-000044-17;
Critical Incident Log #001759-17 / CI 2655-000005-17;
Critical Incident Log #034762-16 / CI 2655-000142-16;
Critical Incident Log #009267-17 / CI 2655-000048-17;
Critical Incident Log #008057-17 / CI 2655-000034-17;
Critical Incident Log #018649-16 / CI 2655-000049-16;
Critical Incident Log #031005-16 / CI 2655-000100-16;
Critical Incident Log #033031-16 / CI 2655-000116-16;
Critical Incident Log #034426-16 / CI 2655-000140-16;
Critical Incident Log #032662-16 / CI 2655-000111-16;
Critical Incident Log #028921-16 / CI 2655-000086-16;
Critical Incident Log #005720-17 / CI 2655-000019-17;
Critical Incident Log #006985-17 / CI 2655-000025-17;
Critical Incident Log #007255-17 / CI 2655-000029-17;
Critical Incident Log #028719-16 / CI 2655-000083-16.

Related to prevention of abuse and neglect and responsive behaviours:
Critical Incident Log #003972-17 / CI 2655-000014-17;
Critical Incident Log #034909-16 / CI 2655-000145-16;
Critical Incident Log #034431-16 / CI 2655-000141-16;
Critical Incident Log #009097-17 / CI 2655-000047-17;
Critical Incident Log #034431-16 / CI 2655-000141-16.

Related to hospitalization and change of condition:
Critical Incident Log #017733-16 / CI 2655-000045-16;
Critical Incident Log #029722-16 / CI 2655-000091-16.

Related to misappropriation of resident money:

Critical Incident Log #032248-16 / CI 2655-000105-16;
Critical Incident Log #033306-16 / CI 2655-000123-16;
Critical Incident Log #032696-16 / CI 2655-000110-16;
Critical Incident Log #007647-17 / CI 2655-000030-17.

Related to medication administration:

Critical Incident Log #026975-16 / CI 2655-000069-16;
Critical Incident Log #005337-17 / CI 2655-000017-17;
Critical Incident Log #026975-16 / CI 2655-000069-16;
Critical Incident Log #028841-16 / CI 2655-000084-16;
Critical Incident Log #001571-17 / CI 2655-000004-17;
Critical Incident Log #031929-16 / CI 2655-000096-16;
Critical Incident Log #031169-16 / CI 2655-000080-16;
Critical Incident Log #027346-16 / CI 2655-000074-16;
Critical Incident Log #027241-16 / CI 2655-000071-16;
Critical Incident Log #032272-16 / CI 2655-000106-16;
Critical Incident Log #002776-17 / CI 2655-000011-17.

Complaints Inspections:
Complaint Log #034492-16 / IL-48435-LO related to preventions of abuse and neglect and responsive behaviours;
Complaint Log #001076-17 / IL-48853-LO related to preventions of abuse and neglect and responsive behaviours;
Complaint Log #006838-17 / IL-50123-LO related to minimizing of restraining;
Complaint Log #000249-17 / IL-48691-LO related to plan of care and skin and wound care;
Complaint Log #003088-17 / IL-49073-LO related to nutrition and hydration;
Complaint Log #005155-17 / IL-49711-LO related to housekeeping.

During the course of the inspection, the inspector(s) spoke with the Long Term Care Administrator, the Director of Resident Care, two Nursing Operations Supervisors, the Food Service Manager, the Housekeeping, Laundry and Safety Manager, two Clinical Nurse Coordinators, five Registered Nurses (RN), fourteen Registered Practical Nurses (RPN), 29 Personal Support Workers (PSWs), two Housekeepers, one Dietary Aide, over four family member and over forty residents.

The inspectors also observed resident rooms and common areas, observed

medication storage areas, observed medication administration, observed residents and the care provided to them, observed meal service, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home and reviewed various meeting minutes.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

The home submitted a Critical Incident System (CIS) Report to the Ministry of Health and Long Term Care (MOHLTC) which was identified as "improper/incompetent treatment of a resident that resulted in harm or risk to a resident". This reported showed that an identified resident sustained an injury during the care provided by identified staff who were using a specific device.

During the inspection Inspector #630 attempted to interview the staff involved in the incident but they were not available.

During interviews with multiple identified staff it was reported that this resident sustained an injury during the care provided by staff who were using a specific device.

The clinical record for this identified resident showed the resident required assistance from staff for safe transferring using a specific device. This record showed that the resident had sustained an injury during the care provided by identified staff who were using a specific device.

The home's investigation record included a document which showed that the management in the home had completed a thorough review of the incident which included interviews with witnesses as well as a mechanical inspection of the specific device. This document stated that the management determined that the accident related to specific device not being properly secured prior to care being provided to the resident.

During the inspection the Administrator told Inspector #630 that they were involved in the investigation into the incident. Through their investigation they determined that the specific device used was not faulty. The Administrator said during the interviews with identified staff they determined the staff must not have made sure that the specific device was on properly before providing care to this identified resident. The Administrator said that transferring resident was one of the most risky things that staff did in the home and it was the expectation in the home that transfers were done properly.

The severity was determined to be a level two as there was potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 20th day of June, 2017

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

Original report signed by the inspector.