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
Dec 21, 22, 2017	2017_533115_0004	025564-17	Complaint

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

TERRI DALY (115)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 10, 2017

This off-site inspection was related to the discharge of a resident from the home.

During the course of the inspection, the inspector(s) spoke with a Care Coordinator at the London Health Sciences Center, the Administrator, the Director of Resident Care and the Assistant Director of Resident Care.

The following Inspection Protocols were used during this inspection:

Admission and Discharge

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. 146. When licensee shall discharge

Specifically failed to comply with the following:

s. 146. (4) A licensee shall discharge a long-stay resident if,
(a) the resident is on a medical absence that exceeds 30 days; O. Reg. 79/10, s. 146 (4).
(b) the resident is on a psychiatric absence that exceeds 60 days; O. Reg. 79/10, s. 146 (4).
(c) the total length of the resident's vacation absences during the calendar year exceeds 21 days; or O. Reg. 79/10, s. 146 (4).
(d) the long-term care home is being closed. O. Reg. 79/10, s. 146 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a long-stay resident was discharged unless the resident was on an absence that exceeded the specified time frame for that specific absence.

A complaint was received on a specific date by the Ministry of Health and Long Term Care from a Care Coordinator from the London Health Sciences Centre related to a potential discharge.

During a telephone interview with the Care Coordinator they stated that a resident from Chelsey Park had been admitted to the hospital on a specific date for a specified absence. On a certain date the hospital was told that the resident was being discharged within 24 hours and that the home had called the resident's family to let them know the discharge plan. The Care Coordinator stated that the resident was being discharged from the home prior to their full absence.

A telephone interview was conducted with the Administrator, Director of Resident Care (DRC) and Assistant Director of Resident Care (ADRC) in relation to the status of the resident. The Administrator acknowledged that the resident had been admitted to the hospital on a specified absence and was discharged from the home on a specific date. The Administrator said that the home did not allow for the full absence to finish prior to making the decision to discharge the resident.

The severity was determined to be a level two with potential for actual harm. The scope of this issue was isolated during this inspection. The home does not have a history of noncompliance in this subsection of the regulation. [s. 146. (4) (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 residents are not discharged prior to exceeding the specified time frame for that specific absence, to be implemented voluntarily.

Issued on this 22nd day of December, 2017

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

Original report signed by the inspector.