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
Feb 28, 2019	2019_607523_0004	002343-19	Complaint

Licensee/Titulaire de permis

CVH (No. 3) GP Inc. as general partner of CVH (No. 3) 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

Chelsey Park
310 Oxford Street West LONDON ON N6H 4N6

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

ALI NASSER (523)

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): February 19, 20 and 21, 2018.

This inspection was conducted for Complaint Log #002343-19 / IL-63828-LO related to specific care concerns.

This inspection was conducted concurrently with inspection for the following Critical Incidents:
Log #000419-19 / CIS #2655-000001-19 related to an outbreak in the home.
Log #001362-19 / CIS #2655-000006-19 related to alleged staff to resident neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), home's Physician, Housekeeping Manager, two Housekeeping staff, three Personal Support Workers and six Registered staff members.

The inspector(s) also observed resident rooms and common areas, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed specific policies and procedures of the home.

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

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	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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A complaint was received on a certain date by the Ministry of Health and Long-Term Care (MOHLTC) infoline related to specific care concerns affecting a specific resident.

On a certain date complainant and the resident's SDM said that the resident had a specific disease onset and a new treatment was initiated and delivered to the resident without the knowledge and the consent of their substitute decision-maker (SDM).

A clinical record review for the resident showed that a new treatment was initiated and delivered on a specific date.

A specific RN reviewed the resident's clinical record and said that the resident had a change in condition and was started on the specific treatment. The RN said that it was an expectation to inform SDMs about change in resident's status and before starting new treatments. The RN said that this would be documented in the progress notes.
The RN reviewed the clinical record and did not find any documented evidence that the SDM was informed of the resident's change in the plan of care.

In an interview the Director of Care (DOC) said that the home's process was for the nurses to inform the SDM of any changes to the specific treatment and this would be noted in the progress notes.

The DOC said that it was the home's expectation that the resident or SDM be informed of any changes to the treatment and to provide consent for this change. [s. 6. (5)]

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 resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

Issued on this 28th day of February, 2019

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

Original report signed by the inspector.