Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

# Inspection Report under the Long-Term Care Homes Act, 2007

# 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**

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300


**Public Copy/Copie du public**

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jul 4, 2019 | 2019_778563_0020 | 010196-19, 011149-19 | Complaint |

## Licensee/Titulaire de permis

CVH (No. 3) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
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

MELANIE NORTHEY (563)

## 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): June 17, 18, 19 and 20, 2019**

**During the course of the inspection, the inspector(s) spoke with two Directors of Resident Care, Registered Practical Nurses, Personal Support Workers, residents and family.**

**The inspector(s) also reviewed the reporting and complaint process, discharge records and investigation notes. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were also reviewed.**

**The following Inspection Protocols were used during this inspection:**
**Admission and Discharge**
**Personal Support Services**
**Reporting and Complaints**

**During the course of this inspection, Non-Compliances were issued.**
- **4 WN(s)**
- **2 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 | Légende<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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident, the goals the care was intended to achieve and clear directions to staff and others who provided direct care to the resident.

A) The Ministry of Health and Long Term (MOHLTC) Care Infoline - Complaint Information Report identified a resident who required a specific intervention to meet medical needs associated with a specific diagnosis.

As part of the plan of care for three residents inspected, there were no clear care plan directions related to specific interventions to meet a specific medical therapy provided to three residents.

The Weights and Vitals Summary Report for the residents documented inconsistent monitoring of a specific vital sign. According to the physician's order the residents were to maintain a specific range related to a specific vital sign and this documentation was not completed routinely.

The Registered Practical Nurse (RPN) verified the residents had a physician's order for a specific medical intervention and the RPN verified that the residents did not have the planned care related to the monitoring of a specific vital sign as part of their clinical record.

The Director of Resident Care (DRC) verified that the use of a specific medical intervention was not included in the planned care for the residents. The DRC stated that there was a physician's order, but directions were not clear as part of the interventions in the care plans for the PSWs who were providing the specific intervention or for the registered staff who were monitoring a specific vital sign for the three residents.

The licensee failed to ensure that there was a written plan of care for three residents that set out the planned care related to a specific therapy; the goals the therapy was intended to achieve and clear directions to staff and others who provided direct care related to specific monitoring. [s. 6. (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 there is a written plan of care for each resident that set out the planned care for the resident, the goals the care is intended to achieve and clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.***

---

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 145. When licensee may discharge**

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

**s. 145. (2) For the purposes of subsection (1), the licensee shall be informed by,**
**(a) in the case of a resident who is at the home, the Director of Nursing and Personal Care, the resident's physician or a registered nurse in the extended class attending the resident, after consultation with the interdisciplinary team providing the resident's care; or O. Reg. 79/10, s. 145 (2).**
**(b) in the case of a resident who is absent from the home, the resident's physician or a registered nurse in the extended class attending the resident. O. Reg. 79/10, s. 145 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that, before a resident was discharged under subsection 145(1), the licensee was informed by someone permitted to do so; and, (2) for the purposes of subsection (1), the licensee was not informed by, b) in the case of a resident who was absent from the home, the resident's physician or a registered nurse in the extended class attending the resident.

The Ministry of Health and Long Term Care Infoline - Complaint Information Report was related to the discharge of a resident. The Local Health Integration Network (LHIN) Care Coordinator reported that the Long Term Care (LTC) Home, Chelsey Park, discharged a resident prior to the designated time frame allowed.

Multiple progress notes documented in Point Click care (PCC) identified that the hospital physician was planning to discharge the resident back to the home.

The Director of Resident Care (DRC) stated the home received a phone call from the Social Worker from the hospital who reported that the resident's discharge was planned. The home discharged the resident from Chelsey Park while the resident was still in hospital under the care of a hospital physician.

The licensee discharged the resident from the home when the resident was in hospital at the time of the discharge and only the resident's physician or a registered nurse in the extended class attending the resident in hospital were permitted to discharge the resident from Chelsey Park. [s. 145. (2) (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, before a resident is discharged under subsection 145(1), the licensee is informed by someone permitted to do so; and, (2) for the purposes of subsection (1), the licensee is informed by, b) in the case of a resident who is absent from the home, the resident's physician or a registered nurse in the extended class attending the resident, to be implemented voluntarily.***

---

**WN #3: 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 complied with.

Ontario Regulation 79/10 s. 229 (1) states, "Every licensee of a long-term care home shall ensure that the infection prevention and control program required under subsection 86 (1) of the Act complies with the requirements of this section" and s. 229 (4) states, "The licensee shall ensure that all staff participate in the implementation of the program."

The Long-Term Care Homes (LTCH) Act, 2007, c. 8, s. 86 (1) states, "Every licensee of a long-term care home shall ensure that there is an infection prevention and control program for the home."

The Inspector observed oxygen by concentrator located at left side of a resident's bed and the tubing and nasal prongs were resting in a coil on the floor and under the resident's bed.

The Personal Support Worker (PSW) verified that the oxygen tubing was on the floor and should be off the floor and typically tucked in the handle of the oxygen concentrator. The Director of Resident Care verified the proper storage of oxygen tubing when not in use where oxygen tubing and nasal cannulas were to remain off the floor when not in use as this was an infection control and hygiene issue.

The Extendicare Use of Oxygen Therapy policy RC-16-01-16 last updated February 2017 stated, "Ensure appropriate supplies and equipment are available, cleaned and maintained."

The licensee failed to ensure that the Extendicare Use of Oxygen Therapy policy RC-16-01-16 was complied with. [s. 8. (1) (b)]

---

**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information**

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

**s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all required information was posted in a conspicuous and easily accessible location.

The Long-Term Care Homes (LTCH) Act, 2007, c. 8, s. 79 (1) states "Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations." The LTCH Act,2007, s. 79 (2) states, "Every licensee of a long-term care home shall ensure that the required information is communicated, in a manner that complies with any requirements that may be provided for in the regulations, to residents who cannot read the information" and s. 79 (3) states, "The required information for the purposes of subsections (1) and (2) is, (a) the Residents' Bill of Rights."

The Ministry of Health and Long Term (MOHLTC) Care Infoline - Complaint Information Report reported that the posting of the Residents' Bill of Rights was "high up on the wall and cannot be seen by someone in a wheelchair."

The Residents' Bill of Rights was observed posted on each resident care unit. The Bill of Rights was copied onto yellow paper in smaller print, laminated and posted on a bulletin board outside the dining room area. The posting was above the Inspector's eye level and would not be easily accessible to any resident using a wheelchair for locomotion. The resident stated that they were unable to access the information related to the Residents' Bill of Rights because it was posted too high.

A Registered Practical Nurse stated the Residents' Bill of Rights was posted on a bulletin board in the hall outside the dining room and verified that the information was not posted in an easily accessible location for all residents.

The Director of Resident Care (DRC) acknowledged that the Residents' Bill of Rights was posted in the home, but it was not in an easily accessible location for all residents. The DRC shared that it was posted higher so that residents could see the activity calendar and other information more easily on a daily basis.

The licensee has failed to ensure that the Residents' Bill of Rights was posted in a conspicuous and easily accessible location for any resident using a wheelchair for mobility. [s. 79. (1)]

---

**Issued on this 19th day of July, 2019**

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

**Original report signed by the inspector.**