Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Original Public Report

Report Issue Date: October 13, 2023
Inspection Number: 2023-1161-0004
Inspection Type: Proactive Compliance Inspection
Licensee: CVH (No. 3) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)
Long Term Care Home and City: Chelsey Park, London

Lead Inspector	**Inspector Digital Signature**
Melanie Northey (563)	Melanie Northey Digitally signed by Melanie Northey Date: 2023.10.13 14:30:33 -04'00'

Additional Inspector(s)
Henry Otoo (000753)
Meagan McGregor (721)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):
September 14, 15, 18, 19, 21, 22, 25, and 26, 2023

The following intake(s) were inspected:

- Intake: #00096161 - Proactive Compliance Inspection 2023

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement

Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 102 (2) (b)

The licensee failed to implement any standard or protocol issued by the Director with respect to infection prevention and control.

Rationale and Summary
The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes stated the following: ADDITIONAL REQUIREMENT UNDER THE STANDARD: 10.1 The licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90 percent (%) Alcohol-Based Hand Rub (ABHR). These agents shall be easily accessible at both point-of care and in other resident and common areas, and any staff providing direct resident care must have immediate access to 70-90% ABHR.

During the initial tour, a resident room was a semi-private room with a contact precaution sign posted and a Personal Protective Equipment (PPE) cart available with one container of Isagel Ethyl Alcohol No Rinse Antiseptic Gel with 60 percent (%) ethyl alcohol. The Infection Prevention and Control Lead verified ABHR used in the home must be at least 70% ethyl alcohol. Staff were responsible to implement measures to prevent the transmission of infections that could put residents at increased risk, including ensuring ABHR is 70-90% ethyl alcohol.

Sources: Observations and staff interviews. [563]

Date Remedy Implemented: September 14, 2023

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.

The licensee failed to ensure that the resident's right to proper nutrition consistent with their needs was fully respected and promoted.

Rationale and Summary
The home's tray service policy indicated that tray service was to be delivered to those residents who were unable to go to the dining room and care staff were responsible for ensuring that residents were offered a choice of beverages and planned menu items and that their diet needs and preferences were provided as required while receiving tray service.

The resident declined to come to the dining room for lunch and was not offered or provided a meal or the nutritional interventions that they required.

The resident indicated they had multiple health concerns which prevented them from attending the dining room. They said that when they did not go to the dining room for meals, they were not provided a meal and when they had asked to be provided a meal in their room in the past, they were told by staff that they could not. They said they did not feel like they got enough to eat when they did not go to the dining room for meals.

A Personal Support Worker (PSW) and a Dietary Aide (DA) said that the resident did not always go to the dining room for meals and that when they declined to come to the dining room for a meal, they were not offered a meal in their room or provided with the nutritional intervention they required. They indicated that residents were only offered meals in their room if they were too sick to come to the dining room or had a written order that allowed them to eat in their room because there were not enough staff members to supervise them while eating in their room.

The Director of Care (DOC) said that if the resident declined to come to the dining room for meals because they were experiencing a health concern, they would expect staff to provide them tray service in their room with a meal and the nutritional interventions they required at a time when a staff member was available to supervise them.

When the resident declined to come to the dining room for meals and was not provided with a meal and nutritional interventions in accordance with their specific needs, there was risk of their nutritional and emotional needs not being met and their right to proper nutrition consistent with their needs was not fully respected and promoted.

Sources: the resident's clinical record, including their care plan, nutrition assessments and progress

notes; the home's "Tray Service" policy; and resident and staff interviews. [721]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)

The licensee has failed to ensure that the care set out in the plan of care for the residents related to their Activities of Daily Living (ADLs) was based on an assessment and the needs and preferences of the resident.

Rationale and Summary
The home's plan of care policy indicated that a 24 hour admission plan of care would be completed using an interdisciplinary team assessment to provide an individualized, comprehensive resident assessment and plan of care in order to maximize and maintain every resident's functional potential and quality of life. Registered nursing staff were responsible for ensuring that the 24 hour admission plan of care included at minimum, assistance and care needs with ADLs and were to ensure that the plan of care was current and available to interdisciplinary team members at all times.

The residents care plans and Kardexes did not include any specific direction related to their bathing, bed mobility, transfer, ambulation, dressing, toileting, continence, personal hygiene and oral care needs.

It was indicated on their resident care indicators sheet that they ambulated with a wheelchair and required a mechanical lift with transfers. There was no specific direction provided to staff related to their bathing, bed mobility, ambulation, dressing, toileting, continence, personal hygiene, and oral care needs.

The Registered Nurse (RN) said that the residents assessed care needs related to their ADLs would be communicated to direct care staff via their Kardex and resident care indicators sheet which should be printed and placed in the Personal Support Worker (PSW) binder at the nursing station.

The Director of Care (DOC) confirmed that the residents care plan, Kardex and resident care indicators sheet did not provide specific direction to staff related to all of their assessed ADL care needs and preferences. They said that under normal circumstances registered nursing staff were responsible for ensuring that a resident's care plan, Kardex and resident care indicators sheet were updated based on an assessment and the needs and preferences of residents, however, due to a significant number of new admissions in the home the Assistant Directors of Care (ADOCs) were primarily responsible for updating resident's care plans at present.

The Executive Director (ED) advised that their corporate office had completed audits of newly admitted resident care plans and were aware that a number of newly admitted resident's care plans were not updated based on the assessed needs and preferences of the resident, however the ADOCs in the home

were still in the process of updating these care plans.

The results of the care plan audits that were completed for these residents identified that both resident's care plans were missing information related to their bladder continence and needed specific information for all ADLs, including bathing, bed mobility, transfer, locomotion on/off unit, dressing, eating, toileting, and personal hygiene.

When the care set out in the plan of care for these residents related to their ADLs was not based on an assessment and the needs and preferences of the resident there was risk of them not receiving care as per their assessed needs and preferences.

Sources: the residents' clinical records, including their care plan, Kardex, resident care indicators sheet, daily flow sheets, and assessments; resident care plan audits; the home's "plan of care" policy; observations of the resident; and resident and staff interviews. [721]

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (a)

The licensee has failed to ensure that a resident who was incontinent received an assessment using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Rationale and Summary
In accordance with the home's continence management program policy, nursing staff were responsible for completing continence assessments using a clinically appropriate assessment tool that was specifically designed for assessing continence upon admission for all residents. A three day elimination monitoring record was to be completed on the resident's admission and once completed the nurse would analyze and complete the continence assessment tool.

The resident's records of care, and interviews with staff and the resident indicated the resident was incontinent of bladder and bowel, wore an incontinence product and required assistance from staff with changing this product.

A continence assessment had been initiated for the resident when they were admitted to the home, however, it was not completed in full. There were no subsequent assessments documented in the resident's clinical record.

The Director of Care (DOC) indicated a continence assessment was expected to be completed for

residents within 72 hours of their admission to the home, after a three day elimination monitoring record was completed. They said an alert would appear on PointClickCare (PCC) for nursing staff to notify the staff working on that shift that this continence assessment needed to be completed.

The Assistant Director of Care (ADOC) confirmed that a continence assessment had been initiated for the resident on admission to the home, however, it was not completed in full. They said that they expected this continence assessment should have been completed and they were not sure why it had not been completed.

By not conducting a continence assessment for the resident, their plan of care was not based on an assessment of their continence care needs and their individual bladder and bowel management care needs were not identified, putting them at risk of their care needs not being met and opportunities missed to improve, maintain or prevent deterioration of current functioning.

Sources: the resident's clinical record, including their daily flow sheets, and assessments; the home's "continence management program" policy; and resident and staff interviews. [721]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control (IPAC).

Rationale and Summary
A) The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes stated the following:
9.1 The licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include:
b) Hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact);
d) Proper use of PPE, including appropriate selection, application, removal, and disposal.
At minimum, Additional Precautions shall include:
e) Point-of-care signage indicating that enhanced IPAC control measures are in place.

The Inspector was provided a list of those residents who required Additional Precautions. For one resident there was no Contact Precaution signage posted at the entrance to the resident's room or bed space indicating enhanced IPAC measures were in place. The IPAC Lead arrived at the unit and verified there was no Contact Precaution signage posted and should since the resident had a supporting diagnosis. The IPAC Lead and Inspector observed a Personal Support Worker (PSW) entering the

resident's room to provide care, did not don a gown or gloves, and the IPAC Lead stopped the PSW and asked which resident they were providing care to and the PSW identified the resident without the Contact Precaution signage posted. The PSW said they did not know that the resident was on contact precautions and stated there was no signage that would be used as a point of reference before entering. There was a Personal Protective Equipment (PPE) cart, PPE donning/doffing signage, a PPE disposal receptacle available and there was a red piece of tape at the resident's name plate to identify that the resident was the identified resident on precautions in the semi-private room. The IPAC Lead stated there were other identifiers for the PSW to follow enhanced IPAC measures.

The following week the Inspector observed that another PSW was entering the same resident's room to provide care and the PSW did not don a gown or gloves and closed the door to the resident's room. The PSW opened the door and there was another PSW present who was wearing gloves and no gown. The PSW was observed to doff gloves and dispose in the garbage inside the resident's room with no hand hygiene observed and walked down the hall with the battery for the lift and returned with another battery. The PSW verified they provided care to the resident. There was Contact Precaution signage posted at the entrance to the resident's room, Personal Protective Equipment (PPE) cart was available, donning/doffing signage posted, a PPE disposal receptacle was available and there was a red piece of tape at the resident's name plate to identify that the resident was the identified resident on precautions in the semi-private room. The PSW did not ensure that routine practices and additional precautions were followed as part of the IPAC program. There was point-of-care signage indicating that enhanced IPAC control measures were in place, but the PSWs did not ensure proper use of PPE was followed. The PSW did not perform hand hygiene as required after resident care.

Another resident was identified with a supporting diagnosis for contact precautions. There was no Contact Precaution signage posted at the entrance to the resident's room or bed space indicating enhanced IPAC measures were in place. There was no PPE cart beside the resident's door, no donning/doffing signage, no PPE disposal receptacle available and there was no red tape at the resident's name plate to identify that the resident was the identified resident on precautions in the semi-private room. The IPAC Lead verified the resident had a supporting diagnosis and provided the results of the PPE audit for the resident's room that was signed as completed with no concerns four days prior. At some point over four days the enhanced precautions for the resident were removed and the IPAC Lead could not provide any information as to why that happened. The IPAC Lead stated there was a high probability that care staff entered the room during the four days without donning PPE. The Registered Nurse (RN) verified the resident had a supporting diagnosis as part of the plan of care and there was no Contact Precaution signage or PPE in place.

Southbridge Care Homes Contact Precautions Policy documented a procedure that included, "As soon as possible, the home must post Contact Precaution signage on the resident's door once a disease transmitted by contact is suspected or confirmed. Post Personal Protective Equipment (PPE) donning signage on the resident's door; place and stock PPE carts beside the resident's door and ensure Alcohol-based Hand Rub is available for hand hygiene; post PPE doffing signage inside at the exit of the resident's

room; place a waste bin inside the room beside the door for the disposal of used PPE. Contact Precautions signs should not be removed until the resident has resolved, transferred or deceased and terminal cleaning has been completed."

It was the responsibility of all staff to keep residents healthy and prevent the spread of respiratory and diarrheal infections. Germs can spread from person to person or from surfaces to people. PPE protects healthcare workers from virulent pathogens by preventing exposure to bodily fluids and respiratory droplets. The appropriate use of PPE and hand hygiene was not implemented putting residents at risk, and those strategies have been effective interventions for protecting both residents and healthcare providers from transmissible pathogens.

Sources: observations, clinical record reviews and staff interviews. [563]

B) The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes stated the following: ADDITIONAL REQUIREMENT UNDER THE STANDARD: 10.4 The Licensee shall ensure that the hand hygiene program also includes policies and procedures, as a component of the overall IPAC program, as well as: (h) Support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting.

Observations completed during meal services found residents were not assisted to perform hand hygiene before eating. Dietary staff confirmed that hand hygiene for residents was not done before eating and the IPAC Lead verified that staff were required to assist all residents with hand hygiene before meals. The home's IPAC policy stated residents must be encouraged or assisted to perform hand hygiene in the dining room before and after eating, and it was also part of staff education.

Sources: Observations, record reviews, and staff interviews. [000753]

WRITTEN NOTIFICATION: Critical Incident Reporting

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

The licensee failed to ensure that the Director of the Ministry of Long-Term Care (MLTC) was immediately informed, in as much detail as is possible in the circumstances, of the COVID-19 outbreak.

Rationale and Summary
On September 22, 2023, the Infection Prevention and Control (IPAC) Lead stated there was a suspected COVID outbreak and that Public Health was notified and recommendations were received to cohort staff, to ensure all residents were to remain in their rooms and meal service was to be provided in resident rooms. The IPAC Lead stated the case definition was two residents who presented symptoms and had a positive Rapid Antigen Test (RAT) or Polymerase Chain Reaction (PCR) test and there was a link between

the two residents. The COVID outbreak was declared by Public Health on Saturday September 23, 2023.

Ontario Regulation 246/22, s. 115 (2) states, "Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact."

The Critical Incident Report documented an incident date and time of September 23, 2023, at 0900 hours. The date and time the incident was first submitted to MLTC was September 25, 2023, at 1103 hours.

The Director of Care (DOC) stated the IPAC Lead understood the home had three business days to report the outbreak and verified the home failed to report the COVID outbreak immediately to the Director of the MLTC on September 23, 2023.

Sources: Critical Incident Report, resident clinical records, observations, and staff interviews. [563]

WRITTEN NOTIFICATION: Quarterly Evaluation

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 124 (1)

The licensee has failed to ensure that an interdisciplinary team, including the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Rationale and Summary
During the course of the inspection the home was unable to provide a written record of a quarterly review of the medication management system from the previous quarter which occurred between April and June 2023.

The Director of Care (DOC) indicated that the home was currently in the third quarter and the last quarterly review of the home's medication management system was completed in May 2023 for the first quarter which occurred between January and March 2023. They said that a quarterly review of the home's medication management system from the second quarter which occurred between April and June 2023 had not yet been completed as there was a period of time where the Executive Director (ED) position was vacant and there had been a significant number of new resident admissions.

Sources: Review of the home's Professional Advisory Committee (PAC) meeting minutes and written records of the quarterly review of the home's medication management system; and interviews with the DOC and ED. [721]

WRITTEN NOTIFICATION: Medication Incidents and Adverse Drug Reactions

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (3) (a)

The licensee has failed to ensure that quarterly review was undertaken of all medication incidents, incidents of severe hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon that occurred in the home in order to reduce and prevent medication incidents and adverse drug reactions.

Rationale and Summary
During the course of the inspection the home was unable to provide a written record of a quarterly review of all medication incidents, incidents of severe hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon from the previous quarter of April-June 2023.

The Director of Care (DOC) indicated that the home was currently in the third quarter and the last quarterly review of the home's medication incidents and adverse drug reactions was completed in May 2023 for the first quarter which occurred between January and March 2023. They said that a quarterly review of the home's medication incidents and adverse drug reactions from the second quarter which occurred between April and June 2023 had not yet been completed as there was a period of time where the Executive Director (ED) position was vacant and there had been a significant number of new resident admissions.

Sources: Review of the home's Professional Advisory Committee (PAC) meeting minutes and written records of the quarterly review of the home's medication incidents and adverse drug reactions; and interviews with the DOC and ED. [721]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 9.

The licensee failed to ensure that the continuous quality improvement (CQI) committee was composed of at least one member of the home's Residents' Council.

Rationale and Summary
The Residents' Council Meeting Minutes between May 2022 August 2023 were reviewed to determine if the home had asked a resident to join the CQI Committee. There was no documentation that one member of the home's Residents' Council was asked to be a member of the CQI committee.

Continuous Quality Improvement (CQI) and Professional Advisory Committee (PAC) meeting minutes from

January 25, 2023, and May 29, 2023, identified that the membership for CQI included a Resident Member and the spot was "vacant". The Executive Director stated there was a member of Residents' Council at the CQI meetings prior to their discharge from the home in August 2022, but the ED stated there was no documentation found of a CQI meeting prior to January 2023.

A Residents' Council Representative stated they have never heard the term "Continuous Quality Improvement" or "CQI" and was not informed that each home was to have a CQI committee with a member of Residents' Council in attendance at those meetings to discuss quality initiatives in the home. The member stated they had never been asked to join the quality improvement committee and they have not attended meetings since their admission three years ago.

There was no member of Residents' Council present at the CQI and PAC meetings to discuss CQI initiatives. Although PAC and the CQI teams monitor and report on the overall quality of care and services provided in the home and make recommendations regarding priority areas for quality improvement in the home, membership was vacant for a Resident Member. Residents' Council members were not asked to join the CQI committee at any council meetings held between May 2022 and August 2023.

Sources: Residents' Council meeting minutes, CQI policies, resident and staff interviews. [563]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 10.

The licensee failed to ensure that the continuous quality improvement (CQI) committee was composed of at least one member of the home’s Family Council.

Rationale and Summary
The Family Council (FC) Meeting Minutes January 31, 2023 was reviewed to determine if the home had asked a resident to join the CQI Committee. There was no documentation that one member of the home's Family Council was asked to be a member of the CQI committee. The Family Council Meeting minutes dated June 6, 2023, documented a "request for FC to attend Quality- no volunteers to attend at this time."

Continuous Quality Improvement (CQI) and Professional Advisory Committee (PAC) meeting minutes from January 25, 2023, and May 29, 2023, identified that the membership for CQI included a Family Member and the spot was "vacant". The Executive Director stated there was no Family Council between May and August 2022, no documented Family Council meeting minutes prior to January 2023 and stated there was no documentation found of a CQI meeting prior to January 2023.

There was no member of Family Council present at the CQI and PAC meetings to discuss CQI initiatives.

Although PAC and the CQI teams monitor and report on the overall quality of care and services provided in the home and make recommendations regarding priority areas for quality improvement in the home, membership was vacant for a Family Member. Family Council members were not asked to join the CQI committee at any council meeting held in January 2023, the next meeting was June 2023, and the August 2023 meeting was cancelled. A Family Council member stated the council was still trying to understand their role in the home and the member was not asked to join CQI.

Sources: Family Council meeting minutes, CQI policies, family and staff interviews. [563]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (3) 3.

The licensee failed to ensure that the continuous quality improvement (CQI) committee fulfilled their responsibilities to coordinate and support the implementation of the CQI initiative, including preparation of the report on the CQI initiative.

Rationale and Summary
The Executive Director (ED) stated they were the CQI designated lead. There was no documentation identifying the CQI committee members fulfilled their responsibilities to coordinate and support the implementation of the CQI initiative, including preparation of the report on the CQI initiative within three months of the coming into force of this section which was July 11, 2022. The ED stated the interim report for the 2022-2023 fiscal year was prepared by the former Executive Director with the support of the Southbridge Clinical Consultant.

Sources: Review of the home's CQI documentation and staff interviews. [563]

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (1)

The licensee failed to prepare a report on the continuous quality improvement initiative for the home for each fiscal year no later than three months after the end of the fiscal year and publish a copy of each report on its website.

Rationale and Summary
Ontario Regulation 246/22 s. 168 (4) states, "The first report under this section shall be for the fiscal year ending March 31, 2023."

The Southbridge Interim Quality Report 2022 For Chelsey Park Long-Term Care (LTC) July 2022 was the

only report posted to the website. There was no report on the continuous quality improvement (CQI) initiative for the home for each fiscal year no later than three months after the end of the fiscal year dated July 2023. The Executive Director verified there was no CQI report prepared for the fiscal year ending March 31, 2023.

The prepared and published report was required no later than three months after March 31, 2023. Therefore families, residents, staff, and others were not provided the required information related to the name and position of the designated lead for the continuous quality improvement initiative with a written description of the home's priority areas for quality improvement, objectives, policies, procedures and protocols for the continuous quality improvement initiative for the next fiscal year based on the recommendations of the home's continuous quality improvement committee. The report was to inform the public of the written description of the process to monitor and measure progress, identify, and implement adjustments, and communicate outcomes for the home's priority areas for quality improvement in the next fiscal year. There was to be a written record of the Resident and Family/Caregiver Experience Survey taken during the fiscal year, the results of the survey and the results of the survey taken during the fiscal year were communicated, the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey and the dates the actions were implemented and the outcomes of the actions. The report was to inform the public of the role of the Residents' Council and Family Council, if any, and the role of the continuous quality improvement committee in actions taken, and how their actions were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

Sources: CQI documentation and staff interviews. [563]

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (6) (b)

The licensee failed to ensure the interim report prepared under subsection (5) was provided to the Residents' Council and Family Council, if any.

Ontario Regulation 246/22 s. 168 (5) states, "Every licensee of a long-term care home shall, within three months of the coming into force of this section, prepare an interim report for the 2022-2023 fiscal year."

Rationale and Summary
The Residents' Council Meeting Minutes between June 2022 and September 2023 were reviewed and there was no documentation that the interim report was shared with the members of Residents' Council. The Executive Director verified there was no active Family Council in July of 2022, and the report was not directly shared with Residents' Council.

A Residents' Council Representative stated they have never heard the term "Continuous Quality Improvement" or "CQI" and was not informed that each home was to have a CQI committee with a member of Residents' Council in attendance at those meetings to discuss quality initiatives in the home. The member stated they knew about the home's website but were unaware that there was a CQI Interim Report published and verified the report was not shared with Residents' Council and they attend every meeting and have been a member for three years.

Residents' Council members were not made aware of the report published to the website. The report would have informed the council of the name and position of the designated lead for the continuous quality improvement initiative, the written description of the home's priority areas for quality improvement, objectives, policies, procedures and protocols for the continuous quality improvement initiative, the written description of the process used to identify the home's priority areas for quality improvement, and the written description of a process to monitor and measure progress, identify and implement adjustments, and communicate outcomes for the home's priority areas for quality improvement.

Sources: CQI documentation, resident and staff interviews. [563]

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (6) (c) i.

The licensee failed to ensure that the interim report prepared under subsection (5) included the name and position of the designated lead for the continuous quality improvement initiative.

Ontario Regulation 246/22 s. 168 (5) states, "Every licensee of a long-term care home shall, within three months of the coming into force of this section, prepare an interim report for the 2022-2023 fiscal year."

Rationale and Summary
The "Southbridge Interim Quality Report 2022 For Chelsey Park Long-Term Care (LTC) July 2022" did not document of the name and position of the designated lead for the continuous quality improvement initiative.

The Executive Director verified the "Southbridge Interim Quality Report 2022 For Chelsey Park LTC July 2022" was the interim report published July 2022, three months after the Fixing Long-Term Care Act came into force on April 11, 2022, and the report did not identify the name and position of the designated lead for the continuous quality improvement initiative.

Sources: CQI Interim report and staff interviews. [563]

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (6) (c) ii.

The licensee failed to ensure that the interim report prepared under subsection (5) included the written description of the home's priority areas for quality improvement, objectives, policies, procedures and protocols for the continuous quality improvement initiative.

Ontario Regulation 246/22 s. 168 (5) states, "Every licensee of a long-term care home shall, within three months of the coming into force of this section, prepare an interim report for the 2022-2023 fiscal year."

Rationale and Summary
The "Southbridge Interim Quality Report 2022 For Chelsey Park Long-Term Care (LTC) July 2022" did not document the a written description of the home's policies, procedures and protocols for the continuous quality improvement initiative.

The Executive Director verified the "Southbridge Interim Quality Report 2022 For Chelsey Park LTC July 2022" was the interim report published July 2022, three months after the Fixing Long-Term Care Act came into force on April 11, 2022, and verified there was no description of the policies, procedures and protocols for the continuous quality improvement initiative as part of the report.

Sources: CQI Interim report and staff interviews. [563]

COMPLIANCE ORDER CO #001 Plan of Care

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
A) Provide training to all Dietary Aides, Personal Support Workers, and registered nursing staff on the expectations in the home for providing residents with meals and the specific nutrition interventions they require in situations where they do not attend the dining room for meals. A documented record must be maintained of this training, including the date the training was provided, content covered as part of the training, who provided the training, and who attended the training.
B) Conduct weekly audits for the identified resident to ensure that the nutrition care set out in their plan of care is provided to them as specified in the plan. A documented record must be maintained of these audits, including the date the audit was completed, who completed the audit, any concerns identified, and the corrective action taken as a result of the audit. The auditing process must continue until the

Compliance Order has been complied by an inspector.

Grounds
The licensee has failed to ensure that the nutrition care set out in the resident's plan of care was provided to them as specified in the plan.

Rationale and Summary
The home's tray service policy indicated that tray service was to be delivered to those residents who were unable to go to the dining room and care staff were responsible for ensuring that residents were offered a choice of beverages and planned menu items and that their diet needs and preferences were provided as required while receiving tray service.

It was identified in the resident's plan of care that they were at high nutrition risk, were prescribed a specific nutritional intervention to meet their increased requirements related to multiple supporting diagnoses. The resident had declined to come to the dining room for a meal and was not offered or provided a meal or the nutritional intervention that they required.

The resident indicated they had multiple health concerns which prevented them from attending the dining room. They said that when they did not go to the dining room for meals, they were not provided a meal and when they had asked to be provided a meal in their room in the past, they were told by staff that they could not. They said they did not feel like they got enough to eat when they did not go to the dining room for meals.

A Personal Support Worker (PSW) and a Dietary Aide (DA) said that the resident did not always go to the dining room for meals and that when they declined to come to the dining room for a meal, they were not offered a meal in their room or provided with the nutritional intervention they required. They indicated that residents were only offered meals in their room if they were too sick to come to the dining room or had a written order that allowed them to eat in their room because there were not enough staff members to supervise them while eating in their room.

The PSW indicated they were not aware of the resident requiring any nutritional interventions, that they just ate what was offered on the menu and registered staff were responsible for making sure residents received nutritional interventions.

The Registered Nurse (RN) said dietary staff were responsible for providing residents with meals and nutritional interventions and registered staff would follow-up with dietary staff to ensure that the resident received the nutritional intervention if the resident had an order to do so scheduled on their Medication Administration Record (MAR). They said they were not aware of whether the resident required or was provided any nutritional interventions because they did not have any orders scheduled on their MAR related to supplements.

The Registered Dietitian (RD) said they would expect residents should still be getting required nutritional interventions when they did not come to the dining room for meals, however they could not confirm if that was happening. They indicated that dietary staff were responsible for preparing the nutritional intervention at point of service for residents and PSW staff were responsible for documenting on a resident's intake of supplements under the labelled items section of the daily food and fluid intake sheet located in the dietary binder.

The resident's daily food and fluid intake sheet located in the dietary binder documented that they refused a meal on multiple occurrences, no documentation of their meal intake was completed on multiple occurrences, and there was no documentation of their labelled item intake completed on any occurrence over a course of three weeks.

The Director of Care (DOC) and Executive Director (ED) indicated staff were expected to be offering residents a meal in their room and ensuring nutritional interventions were in place when they declined to go to the dining room. The DOC said that in situations where the resident was refusing to attend the dining room for meals that they would expect them to be provided with a meal and required nutritional interventions in their room.

By not providing the resident with meals and the nutritional interventions that they required there was risk of further deterioration of their nutrition status.

Sources: the resident's clinical record, including their care plan, nutrition assessments, MAR, progress notes, and daily food and fluid intake sheet; the home's "Tray Service" policy; the home's "Food and Fluid Intake Monitoring" policy; observations of the resident and care provided; and resident and staff interviews. [721]

This order must be complied with by November 13, 2023

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
CO issued under FLTCA s.6(7) related to nutrition care on March 31, 2023, as part of Inspection #2023-1161-0001.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.
Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #002 Plan of Care

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (8)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
A) Provide training to all registered nursing staff and Personal Support Workers on the process and expectations in the home for accessing a resident's current plan of care. A documented record must be maintained of this training, including the date the training was provided, content covered as part of the training, who provided the training, and who attended the training.
B) Conduct an audit to ensure that Personal Support Workers have convenient and immediate access to the plan of care for all residents which provides at minimum, information related to the level of assistance and care they require with Activities of Daily Living (ADLs). A documented record must be maintained of this audit, including the date the audit was completed, who completed the audit, the name of the resident the audit was completed for, any concerns identified, and the corrective action taken as a result of the audit. The auditing process must continue until the Compliance Order has been complied by an inspector.

Grounds
The licensee has failed to ensure that the staff and others who provided direct care to three residents were kept aware of the contents of the resident's plans of care and had convenient and immediate access to it.

Rationale and Summary
In accordance with the home's plan of care policy, nursing staff were responsible for ensuring that a residents plan of care included at minimum, assistance and care needs with Activities of Daily Living (ADLs) and that this was current and available to interdisciplinary team members at all times.

Two Personal Support Worker (PSWs) said they would refer to the resident care indicators sheet in the PSW binder located at the nursing station and one PSW said they were new to working in the home and would ask more senior staff and registered nursing staff to find information related to a residents plan of care.

On multiple home care areas, the PSW binders at the nursing stations were reviewed which included a resident care indicators sheet for the residents that provided staff with direction related to their transfer status, however did not provide direction to staff related to their other Activities of Daily Living (ADLs), including bathing, bed mobility, ambulation, dressing, toileting, continence, personal hygiene and oral care needs. The binder did not include a copy of the residents Kardex.

The Registered Nurse (RN) indicated that information related to a resident's specific care needs and plan of care would be communicated to direct care staff via the Kardex. They said that nursing staff were responsible for ensuring that a copy of each resident's Kardex was printed from PointClickCare (PCC) and placed in the PSW binder at the nursing station. They reviewed the PSW binder and confirmed that there was no Kardex printed for the resident and multiple other residents. They said that no PSWs had mentioned anything to them about these residents not having a Kardex in the binder.

The Director of Care (DOC) said that information related to a resident's specific care needs and plan of care would be communicated to direct care staff via the Kardex and resident care indicator sheet that were located in the PSW binders at the nursing stations. They said they would expect that a Kardex should have been printed for these residents and placed in the PSW binders at the nursing stations.

When direct care staff were not provided a copy of the residents Kardex they were not kept aware of the contents of the resident's plans of care and there was risk of these residents not being provided care consistent with their assessed needs and preferences.

Sources: PSW binders; the home's "Plan of Care" policy; and staff interviews. [721]

This order must be complied with by November 27, 2023

COMPLIANCE ORDER CO #003 Nutritional Care and Hydration Programs

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (d)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
A) Develop and implement a process for monitoring and documenting on the provision and intake of nutritional supplements in the home.
B) Provide training to all staff who are responsible for monitoring and documenting on the residents intake of food and fluids on the process and expectations for monitoring and documenting on residents food and fluid intake, including intake of nutritional supplements. A documented record must be maintained of this training, including the date the training was provided, content covered as part of the training, who provided the training, and who attended the training.
C) Conduct weekly audits for the identified residents to ensure that a documented record is maintained of the nutrition care they are provided, including the provision and intake of nutritional supplements. A documented record must be maintained of these audits, including the date the audit was completed, who completed the audit, the name of the resident the audit was completed for, any concerns identified, and the corrective action taken as a result of the audit. The auditing process must continue until the Compliance Order has been complied by an inspector.

Grounds
The licensee has failed to ensure that the provision of the nutrition care set out in the plan of care was documented for the two residents with identified risks related to nutrition and hydration.

Rationale and Summary
Ontario Regulation 246/22, s. 11 (1) (b) states, "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, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system is complied with."

1. In accordance with the home's food and fluid intake monitoring policy, each resident's food and fluid intake was to be monitored as an ongoing indicator of nutritional and hydration status, individually assessed for significant intake changes, and corrective actions were to be taken and outcomes evaluated for identified resident intake concerns. Care staff were responsible for documenting on the residents food and fluid intake after meals and snacks, as close as possible to consumption of meal or snack, and were to report any concerns regarding resident's food or fluid intake to the nurse, including refusals.

Staff indicated that dietary staff were responsible for preparing nutritional interventions at point of service and other nutritional interventions would be sent up to the servery as labelled items and provided to residents.

The Registered Nurse (RN) said dietary staff were responsible for providing residents with supplements and registered staff would follow-up with dietary staff to ensure that a resident received a supplement only if the resident had an order to do so scheduled on their Medication Administration Record (MAR).

A) It was identified for one resident's plan of care that they were at high nutrition risk related to multiple health concerns.

The resident's daily food and fluid intake sheet located in the dietary binder documented that they refused food at all meals and snacks over a three week period of time. Their fluid intake was documented at each meal and snack in mL; however, it was not indicated what specific type of fluid was consumed. There was no documentation completed on any occurrence under the "labelled item" section or indicating whether they were provided with or consumed their boost or resource supplement at each meal.

Their MAR from September 2023 did not include any scheduled orders related to their nutritional interventions.

B) It was identified in another resident's plan of care that they were at high nutrition risk related to multiple health concerns. It was also noted that their food intake was not sufficient to meet estimated requirements and they were to be provided nutritional intervention mixed in a food or beverage of their choice at all meals daily to meet their increased requirements related to a specific diagnosis.

The resident's daily food and fluid intake sheet located in the dietary binder did not include any documentation under the "labelled item" sections or indicate whether they were provided with or consumed their nutritional intervention at each meal between over a three week period.

Their MAR from September 2023 did not include any scheduled orders related to their nutritional intervention.

The Registered Dietitian (RD) said PSW staff were responsible for documenting on a resident's intake of supplements under the labelled items section of each resident's daily food and fluid intake sheet located in the dietary binder. They said they were to refer to this information when completing nutrition assessment to gather information related to a resident's food and fluid intake and acknowledged that the current process for documenting on residents' intake of supplements under the labelled items section did not specify what the specific labelled item being consumed was.

The Director of Care (DOC) and Executive Director (ED) confirmed there was currently no process in place in the home for monitoring whether specific nutritional interventions were provided to residents as required in their plan of care or the quantities of these supplements being consumed.

By not ensuring that the home had a system in place to monitor and evaluate the food and fluid intake of supplements for the two residents with identified risks related to nutrition and hydration, the Registered Dietitian (RD) could not accurately monitor the effectiveness of the plan of care or assess these residents for significant intake changes.

Sources: the resident's clinical records, including their care plan, nutrition assessments, MAR, progress notes, and daily food and fluid intake sheet; the home's "Food and Fluid Intake Monitoring" policy; and staff interviews.

2. In accordance with O. Reg. 274/22 s.11(1)b where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any system, the licensee was required to ensure that the system was complied with.

In accordance with the home's food and fluid intake monitoring policy, each residents food and fluid intake was to be monitored as an ongoing indicator of nutritional and hydration status, individually assessed for significant intake changes, and corrective actions were to be taken and outcomes evaluated for identified resident intake concerns. Care staff were responsible for documenting on the residents food and fluid intake after meals and snacks, as close as possible to consumption of meal or snack, and were to report any concerns regarding resident's food or fluid intake to the nurse, including refusals.

Staff advised that PSW staff were responsible for monitoring and documenting on a residents food and fluid intake in the dietary binder located at the nursing station.

It was identified in a resident's plan of care that they were at high nutrition risk related to multiple health concerns.

A Personal Support Worker (PSW) entered the resident's room and asked if they would like to come to the dining room for lunch. The resident indicated they did not want to come to the dining room for lunch and the PSW proceeded to exit the resident's room without offering to bring them lunch in their room.

The resident's daily food and fluid intake sheet located in the dietary binder at the nursing station was reviewed after lunch which documented that the resident ate a full lunch and the documentation was initialed by the PSW.

The PSW reviewed the resident's daily food and fluid intake sheet in the dietary binder at the nursing station with the Inspector and confirmed that it had been documented that the resident ate a full lunch and documentation of the care being provided had been initialed by them. They confirmed that the resident declined to come to the dining room for lunch and did not eat any lunch that day. They said that another staff member completed the documentation on their behalf, and they signed off on the care and the documentation was incorrect. The PSW proceeded to correct the documentation to reflect that the

resident did not eat any lunch that day.

The Assistant Director of Care (ADOC) indicated that staff should not be documenting on the care that other staff were providing or documenting that care was provided when it was not.

The Inspector shared with the Director of Care (DOC) and the Executive Director (ED) that a staff member had documented on behalf of a PSW that a resident consumed a full meal at lunch when they were observed and confirmed by the PSW not to have eaten any lunch that day. The DOC and ED both stated that was considered false documentation.

When the home failed to comply with the home's system for monitoring and evaluating food and fluid intake for the resident, there was risk of significant changes in their food and fluid intake not being identified and accurate assessments of their nutrition and hydration status not being completed to prevent further deterioration of their nutrition status.

Sources: the resident's clinical record, including their nutrition assessments, progress notes, and daily food and fluid intake sheet; the home's "Food and Fluid Intake Monitoring" policy; observations of the resident and care provided; and staff interviews. [721]

This order must be complied with by November 13, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the

licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.