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

London District
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London, ON, N6A 5R2
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Amended Pubic Report Cover Sheet (A1)

Amended Report Issue Date: March 12, 2024
Original Report Issue Date: February 9, 2024
Inspection Number: 2023-1161-0006 (A1)
Inspection Type: Complaint Critical Incident Follow Up
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

Amended By Melanie Northey (563)	**Inspector who Amended Digital Signature** Melanie Northey Digitally signed by Melanie Northey Date: 2024.03.19 17:43:44 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
The home has requested an extension to the Compliance Order Due Dates for Compliance Orders #001, #002, #003, and #004 from March 15, 2024, to March 29, 2024, due to the priority of the management team focusing resources on an outbreak currently in the home.

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Long Term Care Home and City: Chelsey Park, London	
Lead Inspector Melanie Northey (563)	**Additional Inspector(s)** Rhonda Kukoly (213)
Amended By Melanie Northey (563)	**Inspector who Amended Digital Signature** Melanie Northey Digitally signed by Melanie Northey Date: 2024.03.19 17:44:15 -04'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):
January 3, 4, 5, 8, 9, 10, 11, 12, 15, 16, 17 and 18, 2024

The inspection occurred offsite on the following date(s):
January 24, 2024

The following Critical Incident (CI) intakes were inspected:

- Intake: #00100341 [2655-000032-23] related to Missing Resident

- Intake: #00100433 [2655-000033-23] related to Fall Prevention and Management
- Intake: #00100808 [2655-000035-23] related to Missing Resident
- Intake: #00101062 [2655-000036-23] related to Missing Resident
- Intake: #00103103 [2655-000037-23] related to Prevention of Abuse and Neglect

The following Complaint intakes were inspected:

- Intake: #00099847 related to Resident Care and Support Services, Skin and Wound Care, Housekeeping and Maintenance, Falls Prevention, Infection Prevention and Control, and Air Temperature
- Intake: #00099973 related to Prevention of Abuse and Neglect
- Intake: #00104040 related to Prevention of Abuse and Neglect
- Intake: #00100916 related to Medication Administration and Resident Care and Support Services

The following intake(s) for Follow Up were inspected:

- Intake: #00099377 - Compliance Order (CO) #001 / 2023-1161-0004
- Intake: #00099378 - CO #002 / 2023-1161-0004
- Intake: #00099379 - CO #003 / 2023-1161-0004
- Intake: #00099943 - CO #001 / 2023-1161-0005

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1161-0004 related to FLTCA, 2021, s. 6 (7) inspected by Melanie Northey (563)

Order #002 from Inspection #2023-1161-0004 related to FLTCA, 2021, s. 6 (8) inspected by Melanie Northey (563)

Order #003 from Inspection #2023-1161-0004 related to O. Reg. 246/22, s. 74 (2) (d) inspected by Melanie Northey (563)

Order #001 from Inspection #2023-1161-0005 related to O. Reg. 246/22, s. 140 (2) inspected by Melanie Northey (563)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
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)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary
The plan of care for a resident directed staff to use a specific type of transfer aide and staff assistance. Personal Support Workers stated the care plan did not accurately describe the equipment and staff support the resident required.

The Assistant Director of Care stated the stated that the plan of care did not provide clear direction for staff related to bathing and immediately updated the plan of care.

Sources: Health records for the resident, staff and family interviews. [213]
Date Remedy Implemented: January 17, 2024

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the

information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone, or neglect of a resident by staff that resulted in harm or a risk of harm to the resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary
The Administrator stated a resident's family member complained to the previous Director of Care (DOC) regarding the resident's personal care and the way the resident was spoken to by a staff member.

There was no critical incident report found in the MLTC online Critical Incident Reporting System (CIS), for this resident related to an allegation of neglect or verbal abuse. The Administrator stated that neither the initial allegation of neglect or the allegation of verbal abuse were reported to the Ministry of Long-Term Care (MLTC) and should have been.

There was risk that trends might not have been identified when incidents of a neglect and verbal abuse were not reported to the MLTC Director.

Sources: MLTC CIS, health records for the resident, complaint documentation and staff interviews. [213]

WRITTEN NOTIFICATION: Policy

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 11 (1) (a)

Policies, etc., to be followed, and records

s. 11 (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, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,

(a) is in compliance with and is implemented in accordance with all applicable requirements under the Act; and

The licensee failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was in compliance with all applicable requirements under the Act.

Rationale and Summary

Ontario Regulation (O. Reg.) 246/22, s. 34. (1) states, every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

O. Reg. 246/22, s. 53. (1) 4 states, every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and

implemented in the home: a pain management program to identify pain in residents and manage pain.

O. Reg. 246/22, s. 57 (2) states, every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The Extendicare Pain Identification and Management policy documented a pain assessment would be completed for the following indications:
a. A new pain medication is started;
b. A new, non-pharmacological intervention is initiated; and/or
c. Breakthrough pain medication is used for 3 consecutive days.

The Quality Manager verified the Extendicare Pain Identification and Management policy was the most recent version of the policy and verified the policy did not clearly identify the completion of a clinically appropriate instrument for the purpose of assessing pain when a resident's pain was not relieved by initial interventions. The Quality Manager and Administrator understood that the regulation required the home to institute a policy under for the Pain Management program and verified the policy was not in compliance with all applicable requirements under the Act related to the Pain Management program set out in O. Reg. 246/22, s. 57 (2).

Sources: review of the Pain Assessment policy, and staff interviews. [563]

WRITTEN NOTIFICATION: Doors

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1.
Doors in a home

s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii. equipped with a door access control system that is kept on at all times, and
iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

The licensee has failed to ensure that the door leading to a stairway on the ground floor near the laundry and the staff entrance was kept closed and locked, equipped with a door access control system and equipped with an audible door alarm.

Rationale and Summary
The door leading to a stairway on the ground floor near the laundry and the staff entrance was observed to be held open with a door magnet. There was no keypad, lock or door alarm observed. There were signs on the door stating, "staff area only" and "this door must be kept closed at all times". Three different staff members were observed going through the doorway and leaving the door open.

The Administrator and Quality Manager stated the expectation was that the door was to be kept closed, that there was no lock or alarm system on the door, and there should be. They agreed that there was risk that residents could get into the stairway and get injured or exit the building when staff were not in the area. They stated that a lock and keypad would be installed. They stated the magnet on the

door was removed so that the door could not be held open.

Sources: Observations and staff interviews. [213]

WRITTEN NOTIFICATION: Air Temperature

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2) 1.
Air temperature
s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home.

The licensee has failed to ensure that the air temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home.

Rationale and Summary
Air temperature measurement documentation did not include measurement or documentation of temperatures in any resident rooms from August 1 to November 6, 2023. The Environmental Services Manager stated that after they started in the role, they discovered that temperatures were required to be taken in at least two resident rooms in different areas of the home and changed the process and the form as of November 7, 2023. There was risk that the air temperature was not within a safe or comfortable range when it was not measured in any resident rooms.

Sources: Air temperature records, Preventing Heat-Related Illnesses policy, and staff interviews. [213]

WRITTEN NOTIFICATION: Air Temperature

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 24 (3)

Air temperature

s. 24 (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The licensee has failed to ensure that the temperature required to be measured under Ontario Regulation 246/22 s. 24 (2), was measured or documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Rationale and Summary

The home's air temperature documentation records from August 1 to December 31, 2023 included:

August – 26 out of 93 required times missing documentation for all locations, including day, evening and night shifts

September – 29 out of 90 required times missing documentation for all locations, including day, evening and night shifts

October – 16 out of 93 required times missing documentation for all locations, including day, evening and night shifts

November - 23 out of 90 required times missing documentation for all locations, including day, evening and night shifts

December - 36 out of 93 required times missing documentation for all locations, including day, evening and night shifts

The Environmental Services Manager acknowledged that numerous different required times did not include documentation of air temperatures. There was risk

that the air temperature was not within a safe or comfortable range when it was not measured at the required times.

Sources: Air temperature records, Preventing Heat-Related Illnesses policy, and staff interviews. [213]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that the interdisciplinary program for falls prevention and management to reduce the incidence of falls and the risk of injury was developed and implemented in the home.

Ontario Regulation (O. Reg.) 246/22, s. 34 (1) states every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

O. Reg. 246/22 s. 11. (1) b, the licensee was required to ensure the Extendicare Neurological Signs/Head Injury Routine Policy was complied with.

Rationale and Summary
The Quality Manager verified the Falls Management - Clinical Monitoring Record was the assessment used by the home to assess neurological signs and head injury routine and there was a policy to support the completion of the assessment under the falls prevention and management program.

The Extendicare Neurological Signs/Head Injury Routine policy documented the nurse was to implement a head injury routine and obtain neurological signs whenever a resident experienced or was suspected of sustaining a head injury due to a fall or who have been found on the floor (experienced an unwitnessed fall). The nurse was to continue with head injury routine, assessing neurological indicators every hour for four hours, then if stable, every eight hours for 72 hours.

The Falls Management - Clinical Monitoring Record was completed post fall for a resident. The last one hour neurological check was incomplete and therefore the assessment of the resident was not documented.

The Quality Manager verified the Falls Management- Clinical Monitoring Record was not completed for the fourth hourly check, and explained the fourth hourly check should have been completed at a specific time. And the resident was not assessed at every neurological check point and could have had a change in neurological status that could have negatively impacted their health outcome.

Sources: clinical record review for the resident, policy reviews, and staff interviews. [563]

WRITTEN NOTIFICATION: Pain Management

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 57 (2)

Pain management

s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for that purpose.

Rationale and Summary

A complaint was submitted to the Ministry of Long-Term Care in November 2023, that identified multiple concerns related to a resident.

The Nurse Practitioner (NP) documented a progress note identifying worsening pain for a resident. The NP increased the resident's pain medication.

The home implemented Point of Care (POC) electronic documentation in December 2023, for Personal Support Workers (PSWs) to document care tasks provided. A task for "Pain" asked the PSWs to document every shift a response to the question "Resident complained of pain?". PSWs answered "Yes" that the resident complained of pain during multiple shifts between December 2023 and January 2024. There was no pain assessment completed and no pain medication administered as needed when pain was reported to the PSWs.

The Quality Manager verified the most recent pain assessment for the resident was

completed in 2022, and an assessment should have been completed when the resident complained of worsening pain and any other time when the pain scale was unchanged, or the medication was ineffective. The prescriber should have been contacted. The resident was not assessed using a clinically appropriate assessment instrument when their pain was worse and the pain medication was ineffective.

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

WRITTEN NOTIFICATION: Responsive Behaviours

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (2) (a)
Responsive behaviours
s. 58 (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(a) integrated into the care that is provided to all residents;

The licensee failed to ensure that, for all programs and services, the matters referred to in subsection (1) were integrated into the care that was provided to a resident.

Ontario Regulation 246/22, s. 58. (1) states, every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

Rationale and Summary

The Extendicare Responsive Behaviours policy documented, "Each resident will be assessed and observed for indicators of responsive behaviours on admission, quarterly, and as needed. All new or escalated instances of responsive behaviours will be reported, recorded and investigated on an ongoing basis. The home will implement and evaluate strategies and interventions to prevent, minimize and address responsive behaviours." The policy directed staff to develop a care plan that addressed the risk of any identified behaviours and to provide goals and interventions to promote safe, quality care for every resident with an Aggressive Behaviour Scale (ABS) score of "2" or higher.

The Assessment Scoring Report from Point Click Care (PCC) for the resident identified an ABS of greater than "2" documented as part of three Minimum Data Set (MDS) assessments competed. The care plan was not developed to address the risk of identified specific responsive behaviours. The home's written strategies, including techniques and interventions, to prevent, minimize or respond to the resident's responsive behaviours were not integrated into the care that was provided to the resident. The ABS score of "0 – 12" with higher scores representing greater frequency and intensity of behaviour(s).

The policy also documented two different assessment tools that should be utilized to observe and record a resident's behaviours to assist the team in developing appropriate strategies to manage the resident's behaviour. There was no record of these paper tools as part of the resident's clinical record. The resident monitoring protocols were not followed as described in the policy and therefore were not integrated into the care that was provided to the resident.

The Director of Care (DOC) and the Quality Manager verified the two different assessment tools should have been utilized/referenced to observe and record

behaviours to assist the team in developing appropriate strategies to manage the resident's behaviours. They also verified the care plan was not developed to address the risk of identified behaviours when the resident had an ABS of greater than "2". Care staff and the resident were at risk when the plan of care did not have the specific interventions developed from screening protocols integrated into the care for the resident.

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

WRITTEN NOTIFICATION: Critical Incident Reporting

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 1.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.

The licensee has failed to ensure that the Director was informed of the resident being missing for less than three hours and who returned to the home with no injury or adverse change in condition; no later than one business day after the occurrence of the incident, followed by the report required under Ontario Regulation 246/22 s. 115 (5)

Rationale and Summary
The home reported a critical incident related to a resident having been missing from the home. The report indicated that the resident had four moments of elopement.

There were three critical incident reports for the missing resident.

The Code Yellow – Missing Resident policy stated, residents are considered missing when they are not in a location where staff can find them and are not signed out of the home. The Critical Incident Reporting policy stated, inform the Ministry of Long-Term Care Director no later than one business day after the occurrence of the incident of a resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.

The Administrator stated that they did not notify the Director of the resident missing on a specific date and agreed that they reported the resident as missing on other dates for similar incidents. There was risk that the home did not take appropriate actions related to an incident of a missing resident when they didn't report it as a critical incident report.

Sources: Health records for the resident, The Extendicare Code Yellow – Missing Resident policy, Extendicare Critical Incident Reporting (ON) policy, and staff interviews. [213]

WRITTEN NOTIFICATION: Administration of Drugs

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

Rationale and Summary
The resident was administered a medication that was not prescribed to them. There were no progress notes to indicate the reason for administration or to indicate that the medication was ordered by the resident's physician.

The Director of Care (DOC) and Assistant DOC (ADOC) stated they were notified of a possible medication incident and verified an Agency Registered Practical Nurse (RPN) inputted the medication order for the resident and back dated it without a physician's order, administered the medication and discontinued the order after administration. The Administrator verified the resident was administered a medication that was not prescribed to them, and there were no directions for the use of the medication specified by the prescriber. There was no adverse drug reaction for the resident and the resident was monitored with no concerns.

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

WRITTEN NOTIFICATION: Administration of Drugs

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee failed to ensure that drugs were administered to a resident in

accordance with the directions for use specified by the prescriber.

Rationale and Summary
A complaint was submitted to the Ministry of Long-Term Care that identified multiple concerns related to a resident, including pain management and the administration of medications.

A) A resident showed the inspector that they had medications stored in their clothing and said that the nurse did not stay to make sure their pills were taken.

The Medication Management policy documented the nurse must observe medication for ingestion otherwise it cannot be considered administered, and the nurse was not to leave medication unattended for the resident to self-administer unless the resident performs self-medication administration in adherence to the Self-Administration of Medication policy. The policy also directs the registered nursing staff to immediately document all medication administered, and the Director of Care (DOC) stated the Registered Practical Nurse (RPN) did not administer the medication and the resident was not able to perform self-medication administration. There was no negative outcome to the resident related to the omission of the medication.

The medication tablet was documented as administered on the date and at a time before the resident showed Inspectors the tablet. The DOC verified the RPN did not stay with the resident to ensure administration of the tablet and the medication was not administered to the resident at the time indicated in accordance with the directions for use specified by the prescriber.

B) A resident had a physician's order for a medication four times a day. A review of the medication administration records identified the resident was coded as sleeping

at a specific medication administration time on multiple dates.

The Quality Manager verified the resident was documented as asleep multiple times for the administration of a medication at a specific time. The Administrator stated the expectation was to wake the resident if a resident was asleep and offer the medication. The resident was not administered their medication in accordance with the directions for use specified by the prescriber.

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

WRITTEN NOTIFICATION: Discharge

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 157 (2) (b)
When licensee may discharge
s. 157 (2) For the purposes of subsection (1), the licensee shall be 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.

The licensee failed to be informed by the physician or a registered nurse in the extended class attending the resident.

Ontario Regulation 246/22 s. 157 (1) states, a licensee of a long-term care home may discharge a resident if the licensee is informed by someone permitted to do so under subsection (2) that the resident's requirements for care have changed and that, as a result, the home cannot provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come into contact with the resident.

Rationale and Summary
A resident was sent to hospital and was later discharged from Chelsey Park by email from the licensee's Administrator to Home and Community Care Support Services (HCCSS). There was no record of a discharge notice having been sent to the resident.

The South West Local Health Integration Network, London Health Sciences Centre (LHSC) notes and physician orders for the resident had no documentation from the attending physician in hospital informing the licensee that the requirements for care had changed, as required to support the discharge of the resident from Chelsey Park LTCH.

The Administrator stated, the documents reviewed in the inspection, confirmed that the discharge was done by the home while the resident was in hospital and the home was not informed by the physician or a registered nurse in the extended class attending to the resident in hospital.

Sources: clinical record for the resident, LHSC documentation, and staff interviews. [563]

WRITTEN NOTIFICATION: Resident Records

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee has failed to ensure that a resident's written record was kept up to date at all times.

Rationale and Summary

The resident's family voiced a concern that the resident was found on a different floor than the one they were residing on, and had to be returned to their floor. No progress notes, or any documentation was found related to the resident being found on a different floor on specific dates. The Behavioural Supports Ontario (BSO) Personal Support Worker (PSW) verified the resident had to be returned to their own floor.

Other progress notes indicated the resident was off their floor and was redirected back to the unit and was found again in the elevator exit seeking, but the Point of Care documentation indicated no behaviours were exhibited during the specific shifts.

There were progress notes made by the BSO PSW on that indicated Dementia Observation System (DOS) charting continued due to incomplete charting. The BSO PSW stated that it has been a challenge to get staff to complete the DOS sheets.

The Administrator and the Assistant Director of Care stated that a confused resident being found on another unit with exit seeking behaviours should have been documented. There was risk that behaviours, trends and triggers might not be identified when documentation of the resident's written record was not kept up to date.

Sources: Health records for the resident, family interviews and staff interviews. [213]

COMPLIANCE ORDER CO #001 Plan of Care

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 6 (2)

Plan of care

s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The Licensee has failed to comply with FLTCA, 2021 s. 6 (2)

Specifically, the licensee must:

a) Ensure there is a process in place to update and revise the plan of care to ensure all fall prevention strategies are set out in the plan of care and based on an assessment. Ensure the process includes the appropriate staff have access to the fall prevention strategies as part of the plan of care for implementation. Ensure the process includes the date when the fall prevention and management equipment, supplies, devices or assistive aids were implemented and added to the plan of care for any resident requiring fall strategies to reduce or mitigate falls.

b) Ensure there is a process in place to ensure the fall prevention and management equipment, supplies, devices or assistive aids are readily available at the home to meet the needs of residents at risk for falls and injury.

Grounds

The licensee failed to ensure that the fall prevention care set out in the plan of care was based on an assessment of the needs of a resident.

Rationale and Summary

The resident had an admission progress note that documented the use of specific fall prevention strategies. The falls admission assessment indicated the resident

required fall prevention strategies.

The resident had a fall and their specific fall prevention strategies were not in place at the time of the fall. The fall prevention care plan for the resident was added at the time of admission, but the specific fall prevention strategies in place were not added to the care plan until after the fall.

The Administrator stated at the time of the resident's admission, the home had the specific fall prevention strategy available, but also had a lot of admissions and were possibly in short supply. The ADOC verified the resident was assessed as requiring specific fall prevention strategies, but that they were not in place at the time of the fall and were not identified as part of the care plan until after the fall. The front line staff did not have the documented interventions related to fall prevention for the resident, putting the resident at risk for not receiving the care and services required to reduce the incidence of injury.

Sources: clinical record review for the resident, and staff interviews. [563]

This order must be complied with by March 29, 2024

COMPLIANCE ORDER CO #002 Plan of Care

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with FLTCA, 2021 s. 6 (10) (c)
Specifically, the licensee must:
a) As part of the interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents, the home is to review the current process and procedure related to the follow up of physician orders when "as needed" (PRN) drugs are ineffective. A documented record of the review and revision, the changes made if any, and who participated must be maintained.
b) Review and revise, as needed, the home's process to ensure all orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act. A documented record of the review and revision, the changes made if any, and who participated must be maintained.
c) Registered nursing staff, including registered agency staff are to review the process related to the follow up of physician orders when "as needed" (PRN) drugs are ineffective.
d) Registered nursing staff, including registered agency staff are to review the home's process to ensure all orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act.
e) The home must maintain a written record of the review identified in c) and d), which includes who participated in the review, the date the review was conducted.

Grounds
The licensee failed to ensure that the resident was reassessed, and the plan of care reviewed when the care set out in the plan had not been effective related to the administration of a medication.

Rationale and Summary
The resident had a physician's order for a medication as needed (PRN). Multiple progress notes indicated the resident required the administration of the medication. Progress notes documented the resident's behaviours were unresolved and affecting other residents, putting themselves and staff at risk for injury.

The on-call physician advised to continue to use the current order for the medication as needed and to follow up with the team at rounds to consider initiation of regularly scheduled medication. The PRN medication was administered and documented as ineffective over the course of several days.

The resident's behaviours were not managed with the use of the PRN medication. When the medical care set out in the plan was not effective, the order for the PRN medication was not reviewed and revised when behaviours were escalating. There were no other changes made to the resident's medication orders.

Sources: clinical record for the resident, and staff interviews. [563]

This order must be complied with by March 29, 2024

COMPLIANCE ORDER CO #003 Duty to Protect

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:

The Licensee has failed to comply with FLTCA, 2021 s. 24 (1)

Specifically, the licensee must:

a) Ensure the resident's wounds and areas of altered skin integrity are assessed weekly and any other time as needed.

b) Ensure the resident receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required. Ensure treatment and interventions are documented as part of the resident's plan of care.

c) Ensure the resident is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented.

d) Ensure the resident's pain is assessed using a clinically appropriate assessment instrument specifically designed for this purpose when the resident's pain is not relieved by initial interventions.

e) Provide training to all Personal Support Workers on the expectations in the home for providing residents with skin and wound 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.

f) Provide training to all registered nursing staff on the expectations in the home for providing skin and wound care for those residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds. Training is to include the screening protocols, assessment and reassessment instruments, and the provision of routine skin care to maintain skin integrity and prevent wounds. 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.

g) Conduct an audit of the resident's plan of care, and ensure the assessments and referrals are completed and documented and the plan of care is current and

consistent with the needs of the resident. 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 resident was not neglected by the licensee or staff.

Rationale and Summary
Ontario Regulation 246/22, s. 7, for the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A complaint was received by the Ministry of Long-Term Care from the resident's family regarding skin and wound care. On observation during the inspection, the resident had multiple wounds.

The home documented the first picture of the resident's specific wound several months ago and at that time there was also an area of altered skin integrity that eventually healed the same month. The next picture documented was dated several months later and the area had worsened. Although, treatments of the area were initiated several months ago in the Treatment Administration Record (TAR), the first documented assessment of the wound for that specific area of the resident's body was dated last month.

The home documented the first picture of the resident's second wound weeks ago.

The first treatment to the area was several months ago, with no other treatments noted for the specific area and the wound had been deteriorating over months. The first documented use of a specific treatment was last month, and the first documented assessment of the wound was dated last month.

The resident also had several other wounds and areas of altered skin integrity which had appropriate treatments and assessments completed over the course of several months, when no treatments or assessments were completed for other wounds. The resident's wounds were described as painful.

There were no dietary referrals or assessments found related to the three identified wounds.

The resident was administered a pain medication as needed (PRN) with no documentation in the order or in the Medication Administration Record (MAR) regarding where the pain was or what the pain medication was for. It stated in the MAR "prescriber to specify" but did not specify. The medication was administered multiple times, on an as needed basis, for pain levels ranging from five to nine. The medication was documented as administered several times for pain levels of five to nine and was documented as ineffective, with no follow up completed.

The resident also had a standing order for pain medication to be administered routinely at specific times. It was documented as administered as ordered. There was no documentation of what pain the medication was for or where the pain was. There was no documentation of pain monitoring or if the medication was effective. The only pain assessment completed for the resident was completed on admission.

Minimum Data Set (MDS) quarterly assessments completed in 2023, all indicated no pain, no pressure ulcers and no stasis ulcers identified.

The care plan for the resident included identified pain, and impaired skin integrity with focus areas related to one specific area only. The altered skin integrity for the specific area was first documented, assessed, and treated one month prior to the initiation of the focus areas. There was nothing in the care plan related to wounds, pain, or pressure relief for the resident's specific wound areas.

The Administrator, the Assistant Director of Care, and the Quality Manager reviewed the documentation of wound assessments, treatments, medication administration, dietary referrals and pain assessments and stated the following:
- the areas of impaired skin integrity should have been immediately noted when they first developed, pictures taken, initial assessment and weekly assessments completed, and they were not
- the areas of impaired skin integrity should have been immediately identified on the TAR with treatments initiated as ordered and wound assessments added to the TAR on a weekly basis, and they were not
- pain assessments should have been completed when pain medication was ineffective, when new areas of altered skin integrity that could cause pain were identified, or when the resident voiced new or worsening pain, and they were not
- pain monitoring should have been completed when a new pain medication was started on an as needed basis and on a regular basis, as well as after it was discontinued to determine if the resident continued to have pain, and it was not
- dietary referrals should have been completed when new areas of altered skin integrity, including the left and right great toe and left second toe were identified, and they were not
- it was confusing that skin/wound assessments, TARs with treatments and weekly assessments, and dietary referrals were completed for various other minor areas of altered skin integrity including bruises and skin tears, but not completed for the necrotic areas on the left and right great toes

- the degree of impairment of both great toes was significant and the lack of assessment was disappointing

The wounds significantly worsened and the resident had unresolved pain over multiple months and the resident was not assessed.

Sources: Observations of the resident, health records for the resident, the Extendicare policies, family interviews and staff interviews, [213]

This order must be complied with by March 29, 2024

This compliance order is also considered a written notification and is being referred to the Director for further action by the Director.

COMPLIANCE ORDER CO #004 Responsive Behaviours

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 58 (4)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The Licensee has failed to comply with O. Reg. 246/22, s. 58 (4).
Specifically, the licensee must:
a) Ensure the resident who was demonstrating exit seeking behaviours; the behavioural triggers for the resident are identified, strategies are developed and implemented to respond to exit seeking behaviours, and the actions taken to respond to the needs of the resident, including assessments, reassessments and interventions and the resident's responses to interventions are documented.
b) Ensure the resident who was demonstrating resistive, verbally aggressive and socially inappropriate responsive behaviours; the behavioural triggers for the resident are identified, strategies are developed and implemented to respond to those behaviours, and the actions taken to respond to the needs of the resident, including assessments, reassessments and interventions and the resident's responses to interventions are documented.
c) Ensure resident who was demonstrating exit seeking behaviours; the behavioural triggers for the resident are identified, strategies are developed and implemented to respond to exit seeking behaviours, and the actions taken to respond to the needs of the resident, including assessments, reassessments and interventions and the resident's responses to interventions are documented.
d) Review and revise, as needed, the home's policy related to responsive behaviours and all associated appendices. A documented record of the review and revision, the changes made if any, and who participated must be maintained.
e) Conduct an audit to ensure the plan of care for the identified residents provides, at minimum, the strategies and care they require related to responsive behaviours. 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 when the identified residents were demonstrating specific responsive behaviours, the behavioural triggers for the residents were identified, strategies were developed and implemented to respond to these behaviours, and actions taken to respond to the needs of the resident, including assessments, reassessments and interventions and the resident's responses to interventions documented.

Rationale and Summary

The care plans did not include the responsive behaviours identified for each resident, and did not identify any triggers for the behaviours or specific interventions or strategies to respond to the behaviours.

Minimum Data Set (MDS) Assessments identified behaviours and mood indicators, and there were multiple progress notes documenting specific behaviours for multiple residents.

The Administrator and the Assistant Director of Care (ADOC) stated the care plan did not identify all the residents' behaviours, triggers or clear strategies and interventions for direct care staff to avoid, prevent or manage the residents' responsive behaviours. Director of Care (DOC) and the Quality Manager also verified there were no interventions related to mood indicators and behaviours as identified in the assessments completed or documentation completed through Point of Care documentation for some residents.

Personal Support Workers (PSW) and the Behavioural Supports Ontario (BSO) PSW verified the identified behaviours for the specific residents.

There was risk that the residents could continue to display unmanaged responsive

behaviours that could result in harm to the residents and the staff, when behaviours and triggers were not identified or assessed, and a care plan was not developed that included strategies and interventions for direct care staff to follow. [213] [563]

Sources: clinical record review for the residents; Extendicare Responsive Behaviours policy; Ministry of Long-Term Care Critical Incident System; observations; and resident, family, and staff interviews. [213] [563]

This order must be complied with by March 29, 2024

COMPLIANCE ORDER CO #005 Requirements on Licensee Before Discharging a Resident

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 161 (2)
Requirements on licensee before discharging a resident
s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried;
(b) in collaboration with the appropriate placement coordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident;
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that their wishes are taken into consideration; and
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge

the resident.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The Licensee has failed to comply with O. Reg. 246/22, s. 161 (2).
Specifically, the licensee must:
a) Ensure the management in the home and any other home staff responsible for discharging a resident, reviews the following provisions of O. Reg. 246/22:

- s. 150 related to "Absences",
- s. 156 "Restriction on discharge"
- s. 157 "When licensee may discharge", and
- s. 161 "Requirements on licensee before discharging a resident".

b) A documented record of the review of the legislation outlined in part a) and who participated must be maintained.

c) Review and revise as needed the home's process to discharge a resident from the long-term care home. Ensure the process for discharge is in compliance with and is implemented in accordance with all applicable requirements under the Act and Regulation. A documented record of the review and revision, the changes made if any, and who participated must be maintained.

Grounds

The licensee failed to ensure that the requirements under Ontario Regulation 246/22, s. 161 (2) were met before discharging the resident under subsection 157 (1).

Ontario Regulation 246/22 s. 157 (1) states, a licensee of a long-term care home (LTCH) may discharge a resident if the licensee is informed by someone permitted to do so under subsection (2) that the resident's requirements for care have changed and that, as a result, the home cannot provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come

into contact with the resident.

Rationale and Summary
A resident was sent to hospital and was later discharged from Chelsey Park by email from the licensee's Administrator to Home and Community Care Support Services (HCCSS).

With regard to s, 161 (2) (a), alternatives were not considered and implemented before discharge.

With regard to s. 161 (2) (b), while the Administrator made attempts to contact the HCCSS, they did so after communicating that the resident was not allowed to return to the Long-Term Care home. The Administrator verified there was no ongoing collaboration with the appropriate placement coordinator and there was no other communication with other health service organizations to make alternative arrangements for the accommodation, care and secure environment required by the resident before discharge.

With regard to s. 161 (2) (c), there was no documentation that the resident and the resident's Substitute Decision Maker (SDM) were kept informed and given an opportunity to participate in the discharge planning before the resident was discharged from Chelsey Park. There was no documentation that their wishes were taken into consideration before discharge.

With regard to notice as required under s. 161 (2) (d), there were no documents that meet the requirement of notice before discharge. The Administrator stated the SDM received written notice of the discharge from Chelsey Park after the date of discharge. The SDM letter justified the home's decision to discharge the resident. There was no record of a discharge notice having been sent to the resident.

The home did not ensure the resident was discharged according to the legislation, and in doing so, did not ensure the rights of the resident were fully respected and promoted.

Sources: clinical record for the resident, LHSC documentation, and staff interviews. [563]

This order must be complied with by March 15, 2024

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

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.