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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Original Public Report

Report Issue Date: May 9, 2024
Inspection Number: 2024-1161-0001
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

Lead Inspector	**Inspector Digital Signature**
Samantha Perry (740)	Samantha Perry Digitally signed by Samantha Perry Date: 2024.05.28 15:46:04 -04'00'

Additional Inspector(s)
Brandy MacEachern (000752)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 24, 25, 26, 29, 30, 2024 and May 1, 2, 3, 6, 2024

The following intake(s) were inspected:

- Intake: #00107501 - CIS #2655-000007-24, related to resident abuse;
- Intake: #00107539 - CIS #2655-000006-24, related to resident abuse;
- Intake: #00108733 - Follow-up - Compliance Order (CO) related to O. Reg. 246/22 - s. 58 (4) Responsive Behaviours;

- Intake: #00108734 - Follow-up - CO related to FLTCA, 2021 - s. 24 (1) Duty to protect;
- Intake: #00108735 - Follow-up - CO related to FLTCA, 2021 - s. 6 (10) (c) Plan of Care;
- Intake: #00108736 - Follow-up - CO related to FLTCA, 2021 - s. 6 (2) Plan of Care;
- Intake: #00108737 - Follow-up - CO related to O. Reg. 246/22 - s. 161 (2) Resident discharge;
- Intake: #00109942 - CIS #2655-000013-24, related to alleged resident abuse;
- Intake: #00110198 - Complaint related to residents' morning care routines;
- Intake: #00110539 - Complaint related to residents' sleep patterns and preferences;
- Intake: #00110557 - Complaint related to residents' bill of rights;
- Intake: #00112657 - CIS #2655-000017-24, related to resident abuse;
- Intake: #00113159 - CIS #2655-000020-24, related to the falls management program;

The following intake was completed:

- Intake: #00107051 - CIS #2655-000002-24, related to the falls management program.

Previously Issued Compliance Order(s)

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

Order #004 from Inspection #2023-1161-0006 related to O. Reg. 246/22, s. 58 (4) inspected by Brandy MacEachern (000752)

Order #003 from Inspection #2023-1161-0006 related to FLTCA, 2021, s. 24 (1) inspected by Brandy MacEachern (000752)

Order #002 from Inspection #2023-1161-0006 related to FLTCA, 2021, s. 6 (10) (c) inspected by Brandy MacEachern (000752)

Order #001 from Inspection #2023-1161-0006 related to FLTCA, 2021, s. 6 (2) inspected by Brandy MacEachern (000752)

Order #005 from Inspection #2023-1161-0006 related to O. Reg. 246/22, s. 161 (2) inspected by Brandy MacEachern (000752)

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

Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Residents' Rights and Choices
Falls Prevention and Management
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (5)

Plan of care

s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-

maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given the opportunity to participate fully when a number of residents' plans of care were redeveloped and implemented related to the residents' sleep patterns and preferences.

Rationale and Summary:
The Ministry of Long-Term Care (MLTC) received multiple concerns related to changes implemented to the residents' sleep patterns and preferences.

Through observations, record reviews and in interviews with staff and management, the review supported there were a number of residents whose sleep patterns and preferences were changed and were not consented to by the residents and or the residents' substitute decision-makers (SDM). This increased the residents' risk of interrupted sleep and impacted their individualized rest routines and comfort.

Sources: Resident clinical records, observations and interviews with staff and management. [740]

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to

promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure they complied with their written policy to promote zero tolerance of abuse and neglect of residents.

The home's policy stated that at minimum, any individual who witnessed or suspected abuse, that harmed or created a risk of harm of a resident must notify their management immediately.

a) **Rationale and Summary:**
The Ministry of Long-Term Care received concerns of alleged staff to resident abuse. Which was not reported immediately by staff to the management team.

The Director of Care (DOC) confirmed the staff member should have reported the incident immediately to management. The lack of immediate reporting by staff was not in compliance with the home's policy or the legislative requirements. This caused increased risk to all residents when the incident was not immediately investigated to ensure appropriate actions were then taken in response.

b) **Rationale and Summary:**
The Ministry of Long-Term Care received concerns of alleged staff to resident abuse. Which was not reported immediately by staff to the management team.

The Administrator and Assistant Director of Care (ADOC) both said the registered nurse should have immediately called the on-call manager to report the incident and receive further guidance for next steps in the home's investigation process.

Sources: Southbridge Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct Policy RC-02-01-02, staff interviews, CIS Report. [000752]

WRITTEN NOTIFICATION: Bedtime and rest routines

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 45
Bedtime and rest routines
s. 45. Every licensee of a long-term care home shall ensure that each resident of the home has the resident's desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

The licensee has failed to ensure that multiple residents had their desired and individualized rest routines supported to promote comfort, rest and sleep.

Rationale and Summary:
The Ministry of Long-Term Care (MLTC) received several complaints related to concerns that residents' sleep patterns and preferences were not being supported by the home.

Through the course of the inspection, it was observed and confirmed through interviews that a number of residents had their sleep patterns and preferences changed, which did not support and promote their comfort, rest and sleep.

The Administrator and Director of Care (DOC) both said their expectation was that the residents' sleep patterns and preferences be respected. When the home failed to support the residents' comfort, rest and sleep patterns, it impacted the residents' rest routines and, increased their risk of interrupted sleep.

Sources: Resident clinical record reviews, observations, interviews with staff and management. [740]

WRITTEN NOTIFICATION: Monitoring of all Residents During Meals

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 3.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
3. Monitoring of all residents during meals.

The licensee has failed to ensure that a resident was monitored in their room while eating a meal.

Rationale and Summary:
During the onsite inspection a resident was observed eating in their room without staff supervision.

A record review for the resident documented they had nutritional risk and required supervision at all times while they were eating. Registered Practical Nurse (RPN) acknowledged the resident was eating alone in their room and said they should have been supervised by staff. This increased the resident's risk of choking and impacted their right to care consistent with their needs.

Sources: Observation of resident, Staff interview, The resident's care plan. [000752]