Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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

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

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Sep 25, 2017;	2017_262630_0015 (A1)	012810-16, 015296-16, 017733-16, 018649-16, 026975-16, 027241-16, 027346-16, 028719-16, 028841-16, 028921-16, 029722-16, 031005-16, 031169-16, 031929-16, 032248-16, 032272-16, 032662-16, 032696-16, 033031-16, 033306-16, 034426-16, 034762-16, 034909-16, 001571-17, 001750-17, 002776-17, 003972-17, 005337-17, 005720-17, 006985-17, 007255-17, 007647-17, 008057-17, 008058-17, 008908-17, 009097-17, 009267-17	Critical Incident System

Licensee/Titulaire de permis

CVH (No.3) GP Inc. as general partner of CVH (no.3) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

Rapport d’inspection prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Home/Foyer de soins de longue durée

Chelsey Park
310 OXFORD STREET WEST LONDON ON N6H 4N6

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

AMIE GIBBS-WARD (630) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

This report was amended to correct the Critical Incident System (CIS) report number reference in WN #10 in Licensee Report.

Issued on this 25 day of September 2017 (A1)

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

Original report signed by the inspector.

Ontario

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Chelsey Park
310 OXFORD STREET WEST LONDON ON N6H 4N6

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

AMIE GIBBS-WARD (630) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 5, 6, 7, 8, 9 and 12, 2017.

The following Critical Incident inspections were conducted:

Related to prevention of abuse and neglect:

Critical Incident Log #012810-16 / CI 2655-000040-16;

Critical Incident Log #015296-16 / CI 2655-000044-16;

Critical Incident Log #008908-17 / CI 2655-000044-17;

Critical Incident Log #001759-17 / CI 2655-000005-17;

Critical Incident Log #034762-16 / CI 2655-000142-16;

Critical Incident Log #009267-17 / CI 2655-000048-17;

Critical Incident Log #008057-17 / CI 2655-000034-17;

Critical Incident Log #018649-16 / CI 2655-000049-16;

Critical Incident Log #031005-16 / CI 2655-000100-16;

Critical Incident Log #033031-16 / CI 2655-000116-16;

Critical Incident Log #034426-16 / CI 2655-000140-16;

Critical Incident Log #032662-16 / CI 2655-000111-16;

Critical Incident Log #028921-16 / CI 2655-000086-16;

Critical Incident Log #005720-17 / CI 2655-000019-17;

Critical Incident Log #006985-17 / CI 2655-000025-17;

Critical Incident Log #007255-17 / CI 2655-000029-17;

Critical Incident Log #028719-16 / CI 2655-000083-16.

Related to prevention of abuse and neglect and responsive behaviours:

Critical Incident Log #003972-17 / CI 2655-000014-17;

Critical Incident Log #034909-16 / CI 2655-000145-16;

Critical Incident Log #034431-16 / CI 2655-000141-16;

Critical Incident Log #009097-17 / CI 2655-000047-17.

Related to hospitalization and change of condition:

Critical Incident Log #017733-16 / CI 2655-000045-16;

Critical Incident Log #029722-16 / CI 2655-000091-16.

Related to misappropriation of resident money:

Critical Incident Log #032248-16 / CI 2655-000105-16;

Critical Incident Log #033306-16 / CI 2655-000123-16;

Critical Incident Log #032696-16 / CI 2655-000110-16;

Critical Incident Log #007647-17 / CI 2655-000030-17.

Related to medication administration:

Critical Incident Log #026975-16 / CI 2655-000069-16;

Critical Incident Log #005337-17 / CI 2655-000017-17;

Critical Incident Log #026975-16 / CI 2655-000069-16;

Critical Incident Log #028841-16 / CI 2655-000084-16;

Critical Incident Log #001571-17 / CI 2655-000004-17;

Critical Incident Log #031929-16 / CI 2655-000096-16;

Critical Incident Log #031169-16 / CI 2655-000080-16;

Critical Incident Log #027346-16 / CI 2655-000074-16;

Critical Incident Log #027241-16 / CI 2655-000071-16;

Critical Incident Log #032272-16 / CI 2655-000106-16;

Critical Incident Log #002776-17 / CI 2655-000011-17.

The following intakes were inspected at the same time as this Critical Incident inspection and can be found in separate reports:

Critical Incidents related to falls prevention:

Critical Incident Log #006377-16 / CI 2655-000004-16;

Critical Incident Log #035480-16 / CI 2655-000148-16;

Critical Incident Log #008765-17 / CI 2655-000042-17;

Critical Incident Log #008438-17 / CI 2655-000041-17.

Critical Incidents related to preventions of abuse and neglect and responsive behaviours:

Critical Incident Log #034431-16 / CI 2655-000141-16

Complaints Inspections:

Complaint Log #034492-16 / IL-48435-LO related to preventions of abuse and neglect and responsive behaviours;

Complaint Log #001076-17 / IL-48853-LO related to preventions of abuse and neglect and responsive behaviours;

Complaint Log #006838-17 / IL-50123-LO related to minimizing of restraining;

Complaint Log #000249-17 / IL-48691-LO related to plan of care and skin and wound care;

Complaint Log #003088-17 / IL-49073-LO related to nutrition and hydration;

Complaint Log #005155-17/ IL-49711-LO related to housekeeping.

During the course of the inspection, the inspector(s) spoke with the Long Term Care Administrator, the Director of Resident Care, two Nursing Operations Supervisors, the Food Service Manager, the Housekeeping, Laundry and Safety Manager, two Clinical Nurse Coordinators, five Registered Nurses (RN), fourteen Registered Practical Nurses (RPN), 29 Personal Support Workers (PSWs), two Housekeepers, one Dietary Aide, over four family members and over forty residents.

The inspectors also observed resident rooms and common areas, observed medication storage areas, observed medication administration, observed residents and the care provided to them, observed meal service, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home and reviewed various meeting minutes.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Hospitalization and Change in Condition

Medication

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **11 WN(s)**
- **8 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

The home submitted a Critical Incident System (CIS) Report to the Ministry of Health and Long Term Care (MOHLTC) which documented that an incident occurred which was alleged staff to resident abuse.

A review of internal investigation documentation showed that an identified staff member had admitted to an altercation with an identified resident.

During an interview with this identified staff member they told Inspector #523 that they had treated an identified resident in a way they regretted and that was not how they would normally treat residents.

During an interview with the Administrator they said they had investigated the alleged staff to resident abuse and this identified staff member admitted to abusing the resident in a specific way. The Administrator acknowledged that the staff had abused the resident and said that it was the home's expectation to promote zero abuse or neglect of residents.

2. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

The home submitted a CIS Report to the MOHLTC which documented that there was an incident of alleged abuse by an identified visitor toward an identified resident.

A review of the clinical record for this identified resident showed that staff witnessed an identified visitor touching this resident on two different dates. This clinical record showed that the former Director of Resident Care (DRC) was informed of the second incident.

The home's investigation documentation which was dated the day after the second incident outlined that an alleged abuse toward a resident had occurred and that this was the second occurrence. The documentation stated that the visitor's actions posed a serious risk for residents and included actions taken by the home.

During an interview with an identified staff member, regarding the first incident of alleged abuse, it was reported to Inspector #669 that they had witnessed an identified visitor touching the identified resident. This staff member said they had reported this to an identified Nursing Operations Supervisor (NOS) immediately afterwards.

During an interview with another identified staff member, regarding the second incident of alleged abuse, it was reported to Inspector #669 that they had witnessed an identified visitor touching the identified resident. This staff member said they had reported this to the former DRC immediately afterwards.

During an interview with an identified NOS it was reported to Inspector #669 that they were directed by the former DRC to take no action regarding the first alleged incident of visitor to resident abuse. This NOS acknowledged that if interventions had been implemented following the first incident of alleged abuse the following incident could have been prevented.

During an interview with the Administrator they acknowledged that the incident of touching that occurred by an identified visitor to an identified resident was considered abuse.

3. The licensee of a long-term care home has failed to ensure that an identified resident was not neglected by the licensee or staff.

The home submitted a CIS Report to the MOHLTC which indicated alleged neglect of an identified resident.

In interviews with multiple staff and management during the inspection they stated that this identified had specific skin care concerns and was dependent on staff for care.

During an interview with an identified staff member they told Inspector #633 that the staff working on a specific shift did not provide this resident with multiple types of care that they had required.

The home's investigation notes showed that identified staff working on a specific shift did not provide this resident with multiple types of care that they had required. This documentation also showed that the identified staff agreed that they had not provided this resident the care as ordered by the physician and per the care plan.

During multiple interviews with identified staff members and the Administrator they reported that on a specific date this identified resident did not receive the required care set out in the plan of care and agreed that staff not providing resident care was neglect.

The severity was determined to be a level three as there was actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on May 17, 2017, in a Complaint Inspection #2017_612610_0002 as a as a Voluntary Plan of Correction (VPC). [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

The home submitted a CIS Report to the MOHLTC which indicated alleged neglect

of an identified resident.

The plan of care in the electronic documentation system stated that this identified resident required specific levels of assistance from staff for care and specific types of care.

In interviews multiple staff and management during the inspection they stated that this identified resident had specific skin care concerns and was dependent on staff for care.

The home's investigation notes showed that identified staff working on a specific shift did not provide this resident with multiple types of care that they had required. This documentation also showed that the identified staff agreed that they had not provided this resident the care as ordered and per the care plan.

Record review of the electronic Treatment Administration Record (eTAR) for this resident did not include documentation that the ordered skin treatments were completed on the specified date.

During multiple interviews with identified staff members and the Administrator they reported that on a specific date this identified resident did not receive the required care set out in the plan of care.

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at any time when the resident's care needs changed.

The home submitted a CIS Report to the MOHLTC which was identified as "resident to resident abuse". This report stated that on a specific date a family member had observed an identified resident touching another identified resident inappropriately. This report also stated that the police had investigated and had said there was enough evidence to identify that this specific type of abuse had occurred.

During an interview with an identified family member it was reported to Inspector #630 that they had observed an identified resident touching another resident twice on the same day. This family said they reported this to staff in the home.

During an interview with an identified staff member they reported that they were not aware of any incident that had occurred between these two residents.

During interviews with two identified NOS they told Inspector #630 that they were aware of the incident that occurred between these two resident. Reviewed the plan of care for the identified resident with this NOS and it was acknowledged this resident's plan of care was not updated after the incident to provide direction to staff regarding avoiding contact between these two residents. They said this NOS said it was the expectation in the home that the plan of care would be updated when the care needs changed.

The severity was determined to be a level three as there was actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on August 29, 2016, in Resident Quality Inspection (RQI) #2016_229213_0030 as a Voluntary Plan of Correction (VPC), on October 7, 2015, in a Critical Incident (CI) Inspection as a VPC, on March 2, 2015, in a RQI as a VPC. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the home's resident-staff communication and response system that used sound to alert staff was properly calibrated so that the level of sound was audible to staff.

A review of a CIS Report submitted to the MOHLTC showed that an identified resident had reported to the home that that they had been ringing the call bell for a specific period of time and a specific date and no one had come to see them.

A review of another CIS Report submitted to the MOHLTC on showed that the Substitute Decision Maker (SDM) for a specific resident activated the call bell and it rang for a specific period of time and no one came in to help.

Observations on June 5, 2017, in the fifth floor hallway outside an identified resident's room showed that when activated a light was flashing outside of the resident's room and the resident-staff communication and response system was not audible in that location.

An identified staff member said in an interview that the resident-staff communication and response system sounded at the nursing station, staff were not

able to hear it when they were in resident’s rooms or in the hallways away from the nursing station. This staff member said that they did not carry pagers or phones that would alert them that a resident was calling.

Observations on June 5, 2017, with Inspector #630 on the fifth floor showed that when call bell was activated in an identified resident room the Inspectors were not able to hear the resident-staff communication and response system in the hallway. The Inspectors walked to nursing station and were able to hear the alarm from a panel across the nursing station and there was a button that when pushed silenced that alarm.

Observations on June 5, 2017, with Inspector #630 on third and fourth floors found the resident-staff communication and response system was audible in all the hallways. Observations on second floor found the resident-staff communication and response system was not audible in the hallways away from the nursing stations.

On June 5, 2017, with Inspectors #523 and #630 toured fifth floor with the Administrator regarding the resident-staff communication and response system. The Administrator acknowledged that the resident-staff communication and response system was not audible in the hallway away from the nursing station.

On June 12, 2017, the Administrator told Inspector #630 that they had met with Maintenance staff and contractors regarding the resident-staff communication and response system and the repairs that were needed to ensure the system was audible to all staff on the floors. The Administrator said that they had an older system and the contractor was able to deactivate the "silence button" on the resident-staff communication and response system by the nursing stations. The Administrator reviewed a copy of the "Purchase Order" dated June 12, 2017, with Inspector #630 which showed that the "audible bells for system on wings" had been ordered and was scheduled to be completed by June 16, 2017. The Administrator acknowledged that at the time of the inspection their resident-staff communication and response system was not properly calibrated so that the level of sound was audible to staff and it was the expectation in the home that would be available.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. The home does not have a history of non-compliance in this section of the legislation.

[s. 17. (1) (g)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is equipped with a resident-staff communication and response system that, in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, 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. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the home's written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

The home's policy titled "Zero Tolerance of Resident Abuse and Neglect" last updated "April 2016" stated under reporting procedures: "Any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/ designate/reporting manager or if unavailable to the most senior supervisor on shift at that time."

1) A CIS Report was submitted to MOHLTC which showed that on a specific date a family member reported to the home an incident of alleged staff to resident abuse. The report showed that three staff members were present at the time of the incident.

The home's internal investigation documentation showed that one of the three staff members admitted to abusing the resident.

The Administrator said in an interview with Inspector #523 that a staff member abused the resident, at that time two other staff were present and witnessed the incident but they did not report this to the nurse or manager. The Administrator said that it was the home's expectation the any staff who witness or becomes aware of any actual or alleged abuse or neglect would report that immediately. The Administrator acknowledged that the home's policy for prevention of abuse and neglect was not complied with.

2) A CIS Report was submitted to the MOHLTC and was related to alleged staff to resident abuse of two identified residents. This report stated that an identified staff member was unsure of the exact date that they witnessed the alleged abuse and that it was approximately two and a half weeks prior to the CIS Report date.

The Administrator acknowledged to Inspector #670 that this identified staff member did not report the alleged abuse immediately and should have done this. The Administrator acknowledged that the home's policy for prevention of abuse and neglect was not complied with.

3) A CIS Report was submitted to MOHLTC which showed that on a specific date an identified staff member was told by an identified resident that another identified staff member took the call bell away from them so they would not ring it anymore. The report showed that the staff member who the resident reported this to did not report this incident to the manager or the on call manager.

The Administrator said in an interview with Inspector #523 that the identified staff member was informed by the resident of an alleged incident of abuse/neglect but the staff member did not report this incident to the manager. The Administrator said that it was the home's expectation that any staff who witnessed or became aware of any actual or alleged abuse or neglect would report that immediately. The Administrator acknowledged that the home's policy for prevention of abuse and neglect was not complied with.

4) Another CIS Report was submitted to MOHLTC which was related to alleged staff to resident abuse.

Review of the home's investigation notes showed a written statement from a student stating that they had witnessed an incident of a staff member abusing an identified resident on a specific date. The student subsequently notified their teacher who in turn notified the home.

The Director of Care (DRC) told Inspector #670 that all students in the home were given the same training as all staff related to prevention of abuse and neglect and reporting obligations. The DRC shared that it was the expectation of the home that students and/or their teachers would report any suspected or witnessed verbal abuse immediately. The DRC acknowledged that the incident was not reported to the home until four days after it was witnessed. The DRC acknowledged that the home's policy for prevention of abuse and neglect was not complied with.

5) A CIS Report was submitted to the MOHLTC and was related to alleged verbal abuse.

Review of the home's internal investigation documentation showed that an identified staff member reported to the charge nurse an alleged incident of abuse. Management was notified immediately and the staff member was suspended during investigation. The home's investigation showed that after interview with multiple staff members it was determined that this staff member had been abusive to this resident on multiple occasions for an extended period of time. The documentation showed that none of the staff reported this to management until at the time they witnessed the alleged abuse.

The DRC told Inspector #670 that during the investigation they found that this identified staff member had been abusive to this identified resident . The DRC acknowledged that it would be the expectation of the home that the staff would immediately report any abuse and stated that the staff interviewed during investigation should have reported immediately and did not. The DRC acknowledged that the home's policy for prevention of abuse and neglect was not complied with.

The severity was determined to be a level two as there was potential for actual harm. The scope of this issue was isolated during the course of this inspection. The

home does not have a history of non-compliance in this subsection of the legislation. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse or a resident by anyone or neglect of a resident by the licensee or staff that the licensee knows of, or that was reported to the licensee, was immediately investigated.

A Review of a CIS Report which was submitted to the MOHLTC showed that an identified resident's family member was visiting and said that they rang the call bell for a specific time period and no one came to respond. The report stated that the family member reported this to the Administrator.

The Administrator said that they were aware of the allegations from the family member and this incident was reported to a former DRC who would have addressed the concern and launched an investigation. Administrator told Inspector #523 that they were not able to find any documented evidence that the home had completed an investigation for the alleged incident of neglect and abuse reported by the family member. The Administrator said that they had identified deficiencies in their process and since then they had worked on improving and resolving those deficiencies. The Administrator acknowledged that there was no record of the investigation and said the expectation was for the investigation to be started immediately and completed for any alleged abuse or neglect or a resident.

The severity was determined to be a level two as there was potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home does not have a history of non-compliance in this section of the legislation. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone immediately reported the suspicion and the information upon which it was based to the Director.

1) A CIS Report was submitted to the MOHLTC which identified an alleged resident to resident abuse had occurred on a specific date.

During an interview with an identified family member it was reported to Inspector #630 that they had observed an identified resident touching another resident twice

on the same day. This family said they reported this to staff in the home.

During an interview with an identified staff member they told Inspector #630 that they were notified by another staff member of an alleged resident to resident abuse. They said they spoke with both residents and it was determined that one resident had touched another resident. This staff member said they started the CIS report but did not submit it as this was completed by the management in the home.

During an interview with an identified NOS they told Inspector #630 that they had been involved in investigating this alleged abuse. This NOS reviewed the investigation documentation with Inspector #630 and said they watched the home's video the day after the incident had been reported to staff working on the floor. They said the home did not submit a CIS Report to the MOHLTC when they were notified of the allegation because it was based on verbal report and they thought there was no actual witnesses. This NOS said they submitted the CIS Report the next day after they had verified through watching the video.

During an interview the Administrator told Inspector #630 that it was the expectation in the home that Director was notified of any alleged abuse immediately through the CIS Reporting system. The Administrator said they had recently implemented a new process for submitting CIS Reports which involved the registered staff initiating it in the system but then a designated management or registered staff member would review and add further information and then submit the report to the home. The Administrator acknowledged that the Director was not notified immediately when the home became aware of this allegation of resident to resident abuse.

2) A CIS Report was submitted to the MOHLTC regarding alleged staff to resident abuse which had occurred nine days prior to the day the report was submitted.

The Administrator told Inspector #670 that an identified NOS had received a verbal report from a staff member alleging staff to resident abuse. The Administrator said the CIS Report was completed and submitted to the MOHLTC nine days after it was reported to the NOS. The Administrator said they were unable to determine why the CIS was submitted nine days after the report was received from. The Administrator acknowledged that the Director should have been notified immediately.

3) A review of a CIS Report submitted to the MOHLTC identified alleged abuse from an identified staff member towards an identified resident. This report did not clearly show when the alleged staff to resident abuse had occurred as this CIS was related to multiple residents.

During an interview the Administrator told Inspector #669 that they were not made aware of the alleged abuse at the time it had been observed by staff. The Administrator explained that it was the home's expectation that alleged abuse was reported to the Director immediately through a CIS Report. The Administrator acknowledged that the alleged abuse by was reported to the MOHLTC five days after they were aware of the allegations but it should have been submitted immediately.

4) A CIS Report was submitted to the MOHLTC one day after an alleged staff to resident abuse occured.

Review of the home's internal investigation showed that an identified staff member abused and identified resident on a specific date. The staff member who witnessed the abuse immediately reported the incident to the management.

The DRC acknowledged to Inspector #670 that the home was aware of the incident and had started investigation one day before the Director was notified through the CIS Report. The DRC stated that the CIS should have been done on the day it was reported or at a minimum the MOHLTC reporting line should have been called.

The home's policy Mandatory and Critical Incident Reports RC-11-01-06 stated "Inform the MOH Director immediately, in as much detail as possible in the circumstances, of each of the following incidents in the home: Abuse or 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 Administrator told Inspector #670 that it was the expectation in the home that the Director should have been notified immediately of any alleged incidents of abuse.

5) A CIS Report submitted to the MOHLTC identified abuse by a visitor toward an identified resident on a specific date. This report did not reference another incident of alleged abuse that had occurred a month prior.

This identified resident's electronic records were reviewed and included a note that a staff member witnessed another resident's family member touching the identified resident a month prior to the CIS Report was submitted.

During an interview with an identified staff member, regarding the first incident of alleged abuse, it was reported to Inspector #669 that they had witnessed an identified visitor touching the identified resident. This staff member said they had reported this to an identified Nursing Operations Supervisor (NOS) immediately afterwards.

During an interview with an identified NOS they said they had been informed a month prior to the CIS Report date that this identified resident had been touched inappropriately by an identified visitor. This NOS acknowledged that the incident was considered abuse and stated that they should have reported the incident to the Ministry.

The Administrator was interviewed by Inspector #669 and said that the home did not report the witnessed abuse toward this identified resident to the MOHLTC. The Administrator said that it was the home's expectation that abuse was reported to the MOHLTC immediately.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on August 2, 2016, in Critical Incident (CI) Inspection #2016_229213_0025 as a Voluntary Plan of Correction (VPC), on March 2, 2015, and in Resident Quality Inspection (RQI) #2015_262523_0004 as a VPC. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure any 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: 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, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Findings/Faits saillants :

The licensee has failed to ensure that when a report was made to the Director under subsection 23 (2) of the Act the licensee included the following material in writing in respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone that led to the report: a description of the individuals involved in the incident, including, names of any staff members or other persons who were present at or discovered the incident; analysis and follow-up action, including, the immediate actions that had been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence; and if not everything required under subsection (1) could be provided in a report within 10 days, the licensee failed to make a preliminary report to the Director within 10 days and to provide a final report to the Director within a period of time specified by the Director.

1) A review of a Critical Incident System (CIS) Report submitted to the MOHLTC showed that the SDM reported alleged neglect and abuse of the resident by a certain staff member. Further review of the CIS Report showed the following:
- The CIS Report had no names of the staff member that was present at the time of the incident.
- Under the analysis and follow-up section the home stated "ongoing investigation as an immediate actions have been taken to prevent recurrence."
- Under the long-term actions that were planned to correct the situation it stated "pending results of investigation."

- Under the general notes section, the home was requested by the MOHLTC to amend the CIS Report on a specific date with the outcome of the investigation.
- On June 6, 2017, at the time of the inspection the home had not provided the final report to the Director.

2) A review of another CIS Report which submitted to the MOHLTC and showed that the SDM reported to home alleged incident of staff to resident verbal abuse. Further review of the CIS showed the following:
- Under analysis and follow-up section the home stated "pending investigation-none of the staff that were working that night are working today, two of them are working tomorrow and they will be interviewed."
- Under "what immediate actions have been taken to prevent recurrence" it stated "pending investigation."
- Under "what long-term actions are planned to correct this situation and prevent recurrence" it stated "pending investigation".

The Administrator acknowledged in an interview that the CIS Reports were not completed with the required information and the CIS Reports were not update within the 10 days with the required information. The Administrator said that it was their expectation that CIS Reports would be initiated, updated and completed according to the legislation.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on August 29, 2016, in Resident Quality Inspection (RQI) #2016_229213_0030 as a Voluntary Plan of Correction (VPC), on August 2, 2016, in Critical Incident (CI) Inspection #2016_229213_0025 as a VPC. [s. 104.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that in making a report to the Director under subsection 23 (2) of the Act the licensee includes the following material in writing in respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone that led to the report: a description of the individuals involved in the incident, including, names of any staff members or other persons who were present at or discovered the incident; analysis and follow-up action, including, the immediate actions that have been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence; and if not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (3) The quarterly evaluation of the medication management system must include at least,
(a) reviewing drug utilization trends and drug utilization patterns in the home, including the use of any drug or combination of drugs, including psychotropic drugs, that could potentially place residents at risk; O. Reg. 79/10, s. 115 (3).
(b) reviewing reports of any medication incidents and adverse drug reactions referred to in subsections 135 (2) and (3) and all instances of the restraining of residents by the administration of a drug when immediate action is necessary to prevent serious bodily harm to a resident or to others pursuant to the common law duty referred to in section 36 of the Act; and O. Reg. 79/10, s. 115 (3).
(c) identifying changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 115 (3).

Findings/Faits saillants :

The licensee failed to ensure that the quarterly evaluation of the medication management system included review of reports of any medication incidents.

Review of the October 12, 2016, Service Delivery Team meeting minutes showed that there was no review of medication incidents during the meeting.

Review of the January 11, 2016, Service Delivery Team meeting minutes and review of the quarterly evaluation of the medication management system dated January 11, 2017, for the period of October to December 2016 showed that medication incidents were not included in this evaluation as they were reviewed and discussed with the Director of Resident Care and the Nursing Operation Supervisors during the Medication Safety Management Meeting.

During an interview with the Administrator they shared that medication incidents were being reviewed monthly at the Medication Safety Management meetings that were attended by members of the nursing team, Nursing Operations Supervisors, Director of Resident Care, Education Manager, Clinical Pharmacist and the Administrator. The Administrator shared that the medication incidents were not being reviewed as part of the quarterly evaluation at the Service Delivery Team meetings.

The licensee failed to ensure that the quarterly evaluation of the medication management system included a review of the medication incidents. [s. 115. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the quarterly evaluation of the medication management system includes reviewing reports of any medication incidents and adverse drug reactions referred to in subsections 135 (2) and (3), to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

The licensee failed to ensure that every medication incident involving a resident was reported to the Medical Director.

Review of CIS Reports submitted to the MOHLTC showed identified seven specific incidents that occurred related to medication incidents for identified residents between May 2016 and March 2017.

During interviews with the DRC and an identified Nursing Operations Supervisor (NOS) they shared that the above medication incidents were not reported to the Medical Director. They shared that attending physician who ordered the medication was advised of the medication incidents but not the Medical Director.

The licensee failed to ensure that every medication incident involving a resident was reported to the Medical Director.

The severity was determined to be a level one as there was minimal risk of harm. The scope of this issue was widespread during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 135. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident is reported to the Medical Director, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

The home submitted a CIS Report to the MOHLTC which was identified as "resident to resident abuse". This report stated that on a specific date a family member had observed an identified resident touching another identified resident. This report also stated that the police had investigated and had said there was enough evidence to identify that this specific type of abuse had occurred.

During an interview with an identified family member it was reported to Inspector #630 that they had observed an identified resident touching another resident twice on the same day. This family said they reported this to staff in the home.

During an interview with an identified staff member it was reported that they had been notified of this alleged resident to resident abuse. This staff member said they spoke with both identified residents involved and it was determined that the one resident had touched the other resident. This staff member said they did not call the police at the time as the incident had occurred two days prior and there was no injury and no complaints or concerns from the family.

During an interview with an identified NOS they told Inspector #630 that they had been involved in investigating and follow-up regarding this alleged abuse. This NOS reviewed the investigation documentation with Inspector #630 and said they watched the home's video and called the police the day after the incident was reported to the staff on the floor. They said they did not call the police on when they were notified of the allegation because it was based on verbal report and they thought there was no actual witnesses. This NOS said they called the next day after they had verified through watching the video. This NOS said that after the

incident was investigated by police they had determined that a specific type of abuse had occurred.

The Administrator told Inspector #630 that it is the expectation in the home that the police were to be notified immediately of any alleged abuse of this nature. The Administrator acknowledged that the police were not notified immediately for this incident when the registered staff had been made aware of the alleged abuse. The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 98.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (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 (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

The licensee failed to ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident: a missing or unaccounted for controlled substance.

A CIS Report was submitted by the home for a controlled substance that was missing/unaccounted for on a specific date. The CIS Report stated that on specific dates while completing an audit on medication incident reports it was noted that a missing medication for an identified resident had not been reported to the MOHLTC.

Record review showed that an identified staff had completed a Long Term Care Medication Incident Report for this resident which stated that an identified registered staff had reported to them that this resident's medication was not in place. The former DRC signed the Long Term Care Medication Incident Report.

During an interview with the Administrator they shared that they gained knowledge that the former DRC had not reported the missing controlled substance to the MOHLTC.

The Administrator shared that the former DRC should have submitted the Critical Incident Report at the time of the incident as they had received the Long Term Care Medication Incident Report.

The licensee failed to ensure that the Director was informed of the missing controlled substance no later than one business day after the occurrence of the incident.

The severity was determined to be a level one as there was minimal risk of harm. The scope of this issue was widespread during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 107. (3) 3.]

Issued on this 25 day of September 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

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

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

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : AMIE GIBBS-WARD (630) - (A1)

Inspection No. / No de l'inspection : 2017_262630_0015 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 012810-16, 015296-16, 017733-16, 018649-16, 026975-16, 027241-16, 027346-16, 028719-16, 028841-16, 028921-16, 029722-16, 031005-16, 031169-16, 031929-16, 032248-16, 032272-16, 032662-16, 032696-16, 033031-16, 033306-16, 034426-16, 034762-16, 034909-16, 001571-17, 001750-17, 002776-17, 003972-17, 005337-17, 005720-17, 006985-17, 007255-17, 007647-17, 008057-17, 008058-17, 008908-17, 009097-17, 009267-17 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Sep 25, 2017;(A1)

Licensee / Titulaire de permis : CVH (No.3) GP Inc. as general partner of CVH (no.3) LP
c/o Southbridge Care Homes Inc., 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

LTC Home / Foyer de SLD : Chelsey Park
310 OXFORD STREET WEST, LONDON, ON, N6H-4N6

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Suzi Holster

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To CVH (No.3) GP Inc. as general partner of CVH (no.3) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 19. (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. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee will protect all residents from abuse by anyone. The licensee shall ensure that all residents are not neglected by the licensee or staff.

Re-training shall be provided to all staff and management regarding the home's written policy to promote zero tolerance of abuse, including sexual abuse, verbal abuse and neglect of residents.

The licensee shall ensure that the care set out in the plan of care for an identified resident is provided to the resident as specified in the plan. The licensee shall ensure there is a process in place to monitor the care provided to this identified resident to ensure that care is provided as set out in the plan of care.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

The home submitted a Critical Incident System (CIS) Report to the Ministry of Health and Long Term Care (MOHLTC) which documented that an incident occurred which was alleged staff to resident abuse.

A review of internal investigation documentation showed that an identified staff member had admitted to an altercation with an identified resident.

During an interview with this identified staff member they told Inspector #523 that they had treated an identified resident in a way they regretted and that was not how they would normally treat residents.

During an interview with the Administrator they said they had investigated the alleged staff to resident abuse and this identified staff member admitted to abusing the resident in a specific way. The Administrator acknowledged that the staff had abused the resident and said that it was the home's expectation to promote zero abuse or neglect of residents.

2. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

The home submitted a CIS Report to the MOHLTC which documented that there was an incident of alleged abuse by an identified visitor toward an identified resident.

A review of the clinical record for this identified resident showed that staff witnessed an identified visitor touching this resident on two different dates. This clinical record showed that the former Director of Resident Care (DRC) was informed of the second incident.

The home's investigation documentation which was dated the day after the second incident outlined that an alleged abuse toward a resident had occurred and that this was the second occurrence. The documentation stated that the visitor's actions posed a serious risk for residents and included actions taken by the home.

During an interview with an identified staff member, regarding the first incident of alleged abuse, it was reported to Inspector #669 that they had witnessed an identified visitor touching the identified resident. This staff member said they had reported this to an identified Nursing Operations Supervisor (NOS) immediately afterwards.

During an interview with another identified staff member, regarding the second incident of alleged abuse, it was reported to Inspector #669 that they had witnessed an identified visitor touching the identified resident. This staff member said they had reported this to the former DRC immediately afterwards.

During an interview with an identified NOS it was reported to Inspector #669 that they were directed by the former DRC to take no action regarding the first alleged incident of visitor to resident abuse. This NOS acknowledged that if interventions had been implemented following the first incident of alleged abuse the following incident could have been prevented.

During an interview with the Administrator they acknowledged that the incident of touching that occurred by an identified visitor to an identified resident was considered abuse.

3. The licensee of a long-term care home has failed to ensure that an identified resident was not neglected by the licensee or staff.

The home submitted a CIS Report to the MOHLTC which indicated alleged neglect of an identified resident.

In interviews with multiple staff and management during the inspection they stated that this identified had specific skin care concerns and was dependent on staff for care.

During an interview with an identified staff member they told Inspector #633 that the staff working on a specific shift did not provide this resident with multiple types of care that they had required.

The home's investigation notes showed that identified staff working on a specific shift did not provide this resident with multiple types of care that they had required. This

documentation also showed that the identified staff agreed that they had not provided this resident the care as ordered by the physician and per the care plan.

During multiple interviews with identified staff members and the Administrator they reported that on a specific date this identified resident did not receive the required care set out in the plan of care and agreed that staff not providing resident care was neglect.

The severity was determined to be a level three as there was actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on May 17, 2017, in a Complaint Inspection #2017_612610_0002 as a as a Voluntary Plan of Correction (VPC). [s. 19. (1)] (633)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Sep 29, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 25 day of September 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : AMIE GIBBS-WARD - (A1)

Service Area Office /
Bureau régional de services : London