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 sous la Loi de 2007 sur les foyers de soins de longue durée

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 14, 2018	2018_263524_0013	016400-18	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

Chelsey Park
310 Oxford Street West LONDON ON N6H 4N6

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

INA REYNOLDS (524), AMIE GIBBS-WARD (630), CASSANDRA ALEKSIC (689), JULIE LAMPMAN (522)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): August 20, 21, 22, 23, 24, 27, 28 and 30, 2018.

The following complaint intakes were completed within the Resident Quality Inspection:
Log #023534-17 / Complaint #IL-53420-LO related to falls prevention and management
Log #005788-18 / Complaint #IL-56158-LO related to personal care

Log #015405-18 / Complaint #IL-57598-LO related to resident discharge
Log #014937-18 / Complaint #IL-57530-LO related to resident discharge.

The following critical incidents were completed within the Resident Quality Inspection:
Log #010344-17 / CIS #2655-000053-17 related to prevention of abuse and responsive behaviours
Log #011907-17 / CIS #2655-000063-17 related to prevention of abuse and responsive behaviours
Log #013045-17 / CIS #2655-000067-17 related to prevention of abuse
Log #010556-17 / CIS #2655-000053-17 related to prevention of abuse and responsive behaviours
Log #017968-17 / CIS #2655-000086-17 related to falls prevention and management
Log #019557-17 / CIS #2655-000087-17 related to falls prevention and management
Log #020897-17 / CIS #2655-000090-17 related to transferring and positioning
Log #022597-17 / CIS #2655-000095-17 related to falls prevention and management
Log #023674-17 / CIS #2655-000099-17 related to falls prevention and management
Log #024027-17 / CIS #2655-000106-17 related to falls prevention and management
Log #027102-17 / CIS #2655-000121-17 related to prevention of abuse and responsive behaviours
Log #029623-17 / CIS #2655-000138-17 related to falls prevention and management
Log #001505-18 / CIS #2655-000005-18 related to prevention of abuse and responsive behaviours
Log #003372-18 / CIS #2655-000007-18 related to prevention of abuse and responsive behaviours
Log #003862-18 / CIS #2655-000013-18 related to personal care
Log #005042-18 / CIS #2655-000019-18 related to falls prevention and management
Log #006352-18 / CIS #2655-000014-18 related to infection prevention and control
Log #007207-18 / CIS #2655-000023-18 related to falls prevention and management
Log #008469-18 / CIS #2655-000017-18 related to infection prevention and control
Log #008907-18 / CIS #2655-000030-18 related to falls prevention and management
Log #010607-18 / CIS #2655-000042-18 related to falls prevention and management
Log #011144-18 / CIS #2655-000044-18 related to falls prevention and management
Log #011866-18 / CIS #2655-000053-18 related to falls prevention and management
Log #015110-18 / CIS #2655-000060-18 related to safe and secure
Log #012084-18 / CIS #2655-000052-18 related to prevention of abuse and responsive behaviours
Log #018494-18 / CIS #2655-000064-18 related to falls prevention and management

Log #019530-18 / CIS #2655-000067-18 related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator, two Directors of resident Care, the Education Manager, the Infection Prevention and Control Coordinator, the Clinical Registered Nurse, the Resident Assessment Instrument Coordinator, one Registered Nurse, eleven Registered Practical Nurses, eight Personal Support Workers, one Local Health Integration Network Care Coordinator, the Residents' Council Representative, residents and family members.

The inspector(s) also conducted a tour of the home, observed resident care provisions, resident and staff interactions, medication administration, a medication storage area, infection prevention and control practices, and the general maintenance, cleanliness and condition of the home. Inspectors reviewed residents' clinical records, postings of required information, relevant meeting minutes, internal investigation notes, medication incident reports, and relevant policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

7 WN(s)
6 VPC(s)
0 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.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

On a specific date, an identified resident told inspectors that they had concerns with the personal care they received from some staff in the home. The resident said that some staff would tell them that they could only have one identified personal care products per shift. During this interview the resident's friend told the inspectors that the resident would keep extra personal care products as there were shortages and they had concerns that these had been taken out of the resident's room without permission by a staff member. The resident said that one shift were providing personal care at identified hours daily and this was their preference. The resident said that on other shifts the staff would not assist them.

On a specific date, a PSW said that the resident would provide identified care for themselves during the shift and would frequently refuse assistance from staff with personal care. The PSW said that the identified personal care products were always available. The PSW said that the resident preferred to go to bed at an identified time and at that time they required personal care. The PSW said that the resident "never" asked for assistance with personal care and that the resident was aware when they needed personal care products.

On a specific date, the RPN said that continence care needs were assessed using an assessment form in Point Click Care (PCC). The RPN said that staff would know what care a resident required through the plan of care and a list of personal care products. The RPN said that the resident required assistance with personal care but they had caught this resident providing the identified personal care by themselves without assistance at times. The RPN said that the resident had the ability to ask for what they

wanted for personal care and that was what the staff followed.

Review of the clinical record for the resident showed the following:
- The plan of care did not reflect that the staff were aware that the resident tended to provide the identified personal care themselves without calling for assistance or refused personal care from staff.
- The plan of care did not identify that the resident had the tendency to store extra identified personal care products or refuse assistance with personal care.

On specific date, the Director of Resident Care (DRC) said that the resident would keep extra identified personal care products in their room which had been cleaned out by staff in the home during a specific month, due to safety concerns. The DRC said they were not aware of any other concerns from the resident related to personal care. The DRC said that the resident was able to verbalize their care preferences and ask for assistance from staff and personal care products when needed. The DRC and the inspector reviewed the most recent continence care assessment and the plan of care in PCC for the resident and the DRC acknowledged that the plan of care did not reflect the most recent assessment. The DRC said it was the expectation in the home that the plan of care would reflect the assessment and the current continence care needs of the resident.

Based on these interviews and observations the licensee has failed to ensure that the care set out in the plan of care for the resident was based on the most recent assessment of the resident and the needs and preferences of that resident. [s. 6. (2)]

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 based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care, which was identified as an incident of staff to resident abuse, which was submitted on a specific date.

The Critical Incident Systems (CIS) report was reviewed by the inspector which stated that on a specific date, an identified resident was woken up by Personal Support Workers (PSW) who told the resident that they had to get up for specific identified personal care. The report stated that the resident said they did not need the personal care and the PSWs pulled them up forcefully and proceeded to transfer the resident. According to the CIS report, interviews took place on a specific date with the PSWs, in which the PSWs acknowledged that the resident looked angry and upset. As per the report, a Registered Practical Nurse (RPN) was interviewed on a specific date, and questioned if they were aware of the complaint by the resident. The RPN confirmed that the PSWs had told them that the resident was visually angry and upset about not wanting to get up, but did not report any injury. The report stated that the RPN informed the Charge Nurse about the incident and that they told the identified PSWs at the time to let the resident sleep next time they were upset. The report stated that the RPN who was informed of the incident on a specific date, confirmed that they did not fill out a complaint form or notify the on-call Director of Resident Care or Administrator or follow Ministry of Health standards.

A review of the resident's clinical record by the inspector showed documentation from the RPN on a specific date, which stated that the resident was upset when they were woken from a deep sleep to be transferred from their bed. The note stated that the resident was wondering why they had to get up at that time and were upset because they wanted to sleep.

The home's policy titled Zero Tolerance of Resident Abuse and Neglect: Response and Reporting-RC-02-01-02, last updated April 2017, stated the following:
1. 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.

On a specific date, the Director of Resident Care (DRC) confirmed that the incident occurred on an identified date, as per the home's investigation, however, was not reported as per policy. The DRC said that on a specific date, the resident informed another staff member of the incident and an investigation commenced to determine staff involved, date of the incident, and why the incident was not reported. When asked by the inspector if the incident was considered to be an allegation of abuse or neglect, the DRC stated that there was potential for a PSW in that they spoke in a manner that was inappropriate and did not acknowledge the home's policy to respect the residents wishes to stay in bed. The DRC stated that the expectation for the registered staff was that they should have completed an immediate follow-up with the resident, to complete the complaint form and notify the on-call administrator on the day of the incident. The DRC stated that the RPN received re-training on duty to report, the completion of complaint forms, and mandatory reporting. The Charge Nurse received re-training on resident's rights, duty to report, and zero tolerance for abuse and neglect.

The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect for an identified resident was complied with.

B) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, which was classified by the management in the home as an allegation of resident to resident abuse. This report stated that management in the home reviewed documentation and noted an incident occurring on a specific date and time. This report stated that the management "followed up and investigated due to concerns that incident was discovered during report review. Charting did indicate that some form of inappropriate contact had occurred" between identified residents. The report stated that the "Administrator and Director of Resident Care (DRC) was not notified at the time." The report also stated that management "reviewed camera footage to determine what had occurred and staff actions. During this review, the extent and nature of the contact was deemed" abusive in nature.

During a review of the clinical record for an identified resident, the inspector identified

that prior to the identified date, there were at least twelve previously documented incidents of responsive behaviours of an abusive nature between the identified resident and other residents in the home.

The home's policy titled Zero Tolerance of Resident Abuse and Neglect: Response and Reporting-RC-02-01-02, last updated April 2017, stated the following: "1. 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."

On a specific date, the Director of Resident Care (DRC) told the inspector that the home's written policy on the prevention of abuse and neglect included definitions for resident to resident abuse. The DRC said that if staff witnessed or became aware of an incident of alleged resident to resident abuse they were expected to immediately report it to the on-call administrator and DRC or directly on the unit they would report to the Registered Nurse (RN) who would proceed in contacting the management. The DRC said that based on their abuse decision tree they would submit a mandatory CIS report to the MOHLTC. The DRC said that they were unsure when the first time that staff reported an allegation of resident to resident abuse involving the identified resident as it could have occurred before they had started in the role of DRC. The DRC said that the first time a CIS report related to resident to resident abuse involving this resident was on a specific identified date.

The inspector and DRC reviewed the progress notes for the identified resident and the DRC acknowledged that there were multiple documented incidents of an abusive nature between the resident and other residents on the floor between a specific period of time. The DRC said that to their knowledge, these incidents had not been reported to management and therefore they had not been investigated or reported to the MOHLTC as per the home's policy. The DRC said that based on the home's written policy it was the expectation that these incidents would have been reported to the management of the home and immediately investigated. The DRC said that the incident on a specific date, was not reported to the management right away and was not identified until report review which then led to the investigation and the submission of the CIS to the MOHLTC. The DRC said that staff were disciplined for not following the process as per the written policy on prevention of abuse and neglect.

Based on this record review and interview there were multiple incidents of an abusive nature between the identified resident and other residents in the home between a

specific period of time which were not reported by staff to the management of the home in compliance with the home's written policy on the prevention of abuse and neglect. [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 written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

On a specific date, an identified resident told inspectors that they had a concern that there were staff members in the home who would put them to bed at an identified hour and that they preferred to go to bed at a later time. The resident said that they recently brought forward that concern to staff in the home.

On a specific date, a Personal Support Worker (PSW) said that the practice in the home was to put residents to bed according to the resident's stated needs and wishes. The PSW said that the resident usually preferred to go to bed after certain hours as they like to watch television and would usually go to bed themselves without ringing for assistance.

On a specific date, a Registered Practical Nurse (RPN) said that staff would assist residents to bed at the time that was dependent on what the resident wanted and that

staff would try to ask them when they wanted to go to bed. The RPN said that the identified resident had expressed a concern about evening care being done earlier than their preference as the resident preferred to go to bed around a specific time.

On a specific date, a Registered Nurse (RN) said that the process in the home for determining a resident's sleep preference was to document this on admission and for the staff to ask the resident day to day what time they wanted to go to bed. The RN said that the identified resident was able to express their own preferences for care.

The clinical records for the resident included the following documentation:
- A "24 hr Care Planning Assessment" from admission on a specific date, with no documented assessment related to sleep patterns or preferences.
- The admission progress notes documented in Point Click Care (PCC) did not include documentation related to the resident's sleep preferences.
- The most recent "Interdisciplinary Team Care Conference" assessment documented on a specific date, with no documented assessment related to sleep patterns or preferences.
- The most recent RAI-MDS assessment with Assessment Reference Date (ARD) for a specific date, with no documented assessment related to sleep patterns or preferences.
- A plan of care focus with no details documented related to assessment or interventions for the resident's sleep patterns and preferences.

The home's complaint investigation records included the following:
- A "Complaint Investigation Form" with a specific date, which stated that the resident's friend had verbalized a complaint that the resident was consistently being put to bed at a specific hour when they really wanted to stay up until a later hour. This form also stated that the resident and the friend were "very upset about this and wanted this to stop."
- The summary of actions included "reminder to staff re: current policy."
- An email from the Nursing Operations Supervisor (NOS) with an identified date, to staff which stated "this is a reminder that bedtimes for residents are not to be designed around what is most convenient for staff. We must continue to support our resident's choice in when to go to bed." This email also stated "residents have always had a choice on when they go to bed."

On a specific date, the Director of Resident Care (DRC) said that staff would assist residents to bed based on the resident's stated preferences. When asked if there was a process for determining a resident's sleep preferences, the DRC said that this was looked at when the residents were admitted and then was followed and monitored. The

DRC said that this was expected to be documented in PCC. The DRC and the inspector reviewed the plan of care for the resident and the DRC acknowledged that it did not include details related to the resident's sleep preferences or patterns. The DRC said that the resident was able to express their preferences related to sleep patterns. The DRC said it was the expectation that sleep preferences and patterns would be included in the resident's plan of care.

Based on these interviews and record reviews the licensee has failed to ensure that the plan of care for the resident was based on an interdisciplinary assessment of the resident's sleep patterns and preferences. [s. 26. (3) 21.]

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 plan of care is based on an interdisciplinary assessment of the resident's sleep patterns and preferences, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) 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, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who exhibited altered skin integrity, including pressure ulcers or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

During stage 1 of the Resident Quality Inspection (RQI), the inspector noted through a clinical record review, that an identified resident had areas of altered skin integrity documented on admission to the home on a certain date and had experienced an increase in altered skin integrity the following month.

On a specific date, the Registered Practical Nurse (RPN) said that the process in the home for assessing a new area of compromised skin integrity was to complete the skin integrity assessment. The RPN said that documentation of the care provided to a resident related to skin and wound care was documented in the weekly wound assessment in Point Click Care (PCC).

A review of documentation in PCC for the resident showed that on a specific date, a head to toe skin assessment was completed on admission and showed the resident had compromised skin integrity.

On specific date, the Clinical Registered Nurse (RN) said that according to the home's

process, a head to toe skin assessment was to be completed for new admissions. The Clinical RN said that if a resident exhibited altered skin integrity, a weekly assessment would be completed. The RN reviewed the resident's head to toe skin assessment for an identified date in PCC and stated that the resident had an area of altered skin integrity on a specific part of their body. The Clinical RN categorized the altered skin integrity and that the weekly wound assessments should have been completed for this resident at the time of admission. The Clinical RN confirmed that there was no weekly skin assessments completed in PCC for the resident on admission.

A review of documentation in PCC for the resident showed that on another specific date, a head to toe assessment was completed in PCC upon return to the home and showed the resident had compromised skin integrity on a specific part of their body.

Review of the assessments in PCC for an identified period of time, for the resident showed that the weekly skin assessment was completed two out of six weeks (33 per cent).

On a specific date, the Clinical RN confirmed that the weekly skin assessments were not completed each week under assessments in PCC for the resident's acquired altered skin integrity after their return to the home on a specific date. The Clinical RN stated it would be their expectation that the weekly wound assessments, for the resident's acquired altered skin integrity, should have been completed each week.

The licensee has failed to ensure that the resident's altered skin integrity, including pressure ulcers or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

As part of the Resident Quality Inspection medication incidents were reviewed for the period of April to June 2018. In total there were 24 medication incidents during this time period. The most recent medication incident and two random medication incidents were reviewed.

A) On a specific date, an identified resident was not administered their dose of medication at a specific time as ordered. The Medication Incident Report indicated that a Personal Support Worker had found the resident's medication folded in a medication cup behind the resident's back in the resident's bed. There were no adverse effects to the resident.

B) On a specific date, an identified resident was not administered their multiple medications at a specific time as ordered. The Medication Incident Report indicated that the Registered Practical Nurse signed the medication as being administered but due to distractions and multitasking did not administer the medication to the resident. There were no adverse effects to the resident.

C) On a specific date, an identified resident was not administered their dose of medication at a specific time as ordered. The RPN had failed to administer the resident's medication due to the high volume on the floor and resident interruptions. There were no adverse effects to the resident.

In an interview on a specific date, the Director of Resident Care reviewed the medication incidents and indicated that the medications for the identified resident's were not administered as ordered by the physician.

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 145. When licensee may discharge

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

This inspection was initiated as a result of two complaints received by the Ministry of Health and Long-Term Care on identified dates, regarding an identified resident's discharge from the home.

During a telephone conversation with the resident's family member, they said that the resident was refused re-admission to the home on a specific date, after being assessed and monitored for multiple days. The resident had been transferred for care due to an

alleged resident to resident abuse incident that occurred on an identified date. The family member stated that the resident had been cleared by the care team including the resident's physician, nurse practitioner and the support team to return to Chelsey Park but the home would not allow the resident to return and had decided to discharge them. The family member stated that the care team was willing to partner with the home and collaborate on a care plan but the home refused. The family member confirmed that they do not wish the resident to be returned to Chelsey Park.

Review of the resident's health records showed that on a specific date, the resident was transferred for care, due to an alleged incident of resident to resident abuse with no injuries. A critical incident system (CIS) report was submitted by the home on a specific date.

On a specific date, the progress notes showed that the Care Coordinator (CC) from the South West Local Health Integration Network (LHIN) spoke with the Director of Resident Care (DRC) where the resident had been living since their specific admission date. The CC contacted the DRC to set up a meeting to discuss the discharge of the resident from the care facility and have them transferred back to the home. The CC reported the resident was stable and they were not seeing any responsive behaviours. The DOC noted the name of the treating physician that would be speaking on behalf of the resident's discharge from the care facility.

On a specific date, progress notes of the multidisciplinary teleconference documented by the home's physician indicated that the resident's attending physician thought that the incident was likely a "one-off" event with the resident's physical and cognitive abilities and thought it would not occur again. The progress note further stated that the resident's attending physician was "quite upset" that Chelsey Park was not working with the care facility to have the resident discharged with the medical advice of the resident's physician.

On a specific date, progress notes by the DOC stated that the care facility felt the resident was ready to return given there have been no behaviours noted while at the care facility.

On a specific date, a telephone interview was held with the Care Coordinator (CC) from the South West LHIN. The CC told the inspector that they were concerned about the discharge of the resident and how the home handled the situation. The CC confirmed that a meeting was held on a specific date, with the multidisciplinary team including a

family member to discuss the return of the resident to the home. The CC said that the resident’s physician assessed that the resident was ready to return to the home as there had been no responsive behaviours during the identified assessment period. The CC said that the care team asked the home what else they could do. The CC said that at the end of the meeting, they asked if the resident could return to the home and they said "no". The CC said that the home would not allow the resident to return based on the identified incident. The CC said that the DRC called at a later date to ask about a funding decline. The CC said they took the opportunity at that time to ask again about the return of the resident and the implication was "no" they would not be returning to the home. The CC said there were no further attempts by the home to discuss the return of the resident to Chelsey Park.

Progress notes indicated the resident was discharged from the home on a specific date. Review of the amended CIS report on a specific date, noted there was a conference call with the resident's care team on a specific date, that included their treating physician and team and the home's physician, Administrator and DRC. The CIS report further stated that, “Chelsey Park was open to further discussions" during the duration of the absent leave. "There was no further contact from the care team". On a specific date "the 60 day bed hold had been reached. The resident was discharged from the home as per protocol.”

On a specific date, the Administrator said that the home had an obligation to protect the residents of the home and there was no guarantee that the behaviour would not happen again. The Administrator and the DRC acknowledged that the resident had been assessed and were informed by the resident’s physician they were able to return to Chelsey Park on a specific date. The Administrator and the DRC acknowledged that the resident's attending physician, after consultation with the team, had not informed the home that the requirements for care had changed for the resident.

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

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, before a resident is discharged under subsection 145(1), the licensee is informed by someone permitted to do so; and, (2) for the purposes of subsection (1), the licensee is informed by, b) in the case of a resident who is absent from the home, the resident's physician or a registered nurse in the extended class attending the resident, to be implemented voluntarily.

WN #7: 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 :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's Substitute Decision Maker (SDM), 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.

As part of the Resident Quality Inspection medication incidents were reviewed for the period of April to June 2018. In total there were 24 medication incidents during this time period. The most recent medication incident and two random medication incidents were reviewed.

A) On a specific date, an identified resident was not administered their dose of medication at a specific time as ordered. The Medication Incident Report indicated that their SDM had not been notified.

B) On a specific date, an identified resident was not administered their multiple medications at a specific time as ordered. The Medication Incident Report indicated that resident's Power of Attorney (POA) for personal care was not called. There was also no documentation that the Medical Director (MD) had been notified and no signature from the MD on the Medication Incident Report.

In an interview on specific date, the Director of Resident Care (DRC) reviewed the Medication Incident Report for the first resident and confirmed that resident's SDM was not notified and should have been. The DRC reviewed the Medication Incident Report for the second resident and confirmed that resident's POA for personal care had not been notified and they should have been. The DRC stated that the Quality Assurance Lead had left a note on the Medication Incident Report that the MD needed to sign the report. The DRC stated that the MD would sign the report when it was reviewed with the MD and if the report had not been signed then the MD had not been notified of the medication incident for the resident.

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's Substitute Decision Maker (SDM), 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. [s. 135. (1)]

Issued on this 9th day of October, 2018

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

Original report signed by the inspector.