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 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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130 avenue Dufferin 4ème étage
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 29, 2019	2019_790730_0005	003066-19, 003631-19	Critical Incident System

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

CHRISTINA LEGOUFFE (730), CASSANDRA ALEKSIC (689), CHERYL MCFADDEN (745)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 22, 25 and 26, 2019.

The following intakes were completed in this Critical Incident System Inspection:

Related to falls prevention

Critical Incident Log #003066-19 / CI 2655-000009-19
Critical Incident Log #003631-19 / CI 2655-000011-19

During the course of the inspection, the inspector(s) spoke with a Director of Resident Care (DRC), a Nursing Operations Supervisor (NOS), the Falls Prevention Lead Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the Physiotherapist (PT), and residents.

The inspectors also observed resident rooms and common areas, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, and reviewed the home's investigation documentation for specific Critical Incidents.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	Légende 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. (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 :

1. 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.

A) The home submitted Critical Incident System (CIS) report #2636-000052-18 to the Ministry of Health and Long-Term Care (MOHLTC), which stated that resident #002 had an unwitnessed fall on a specified date. The resident was sent to hospital to be assessed and was diagnosed with a fracture.

A review of the current plan of care for resident #002, stated under interventions: "Hip Protectors applied daily."

A review of the progress notes in PointClickCare (PCC), for resident #002, showed a progress note from Physiotherapist #108, on a specified date, which stated that they had obtained consent from resident #002's Power of Attorney (POA) the previous week for hip protectors to reduce hip injury.

During an interview, PSW #105 stated that they did not believe that resident #002 wore hip protectors.

During an interview, RPN #107, stated that the resident wore hip protectors as an intervention to minimize their risk for falls.

During an interview with Physiotherapist (PT) #108, on a specified date, they stated that they had recommended that resident #002 wore hip protectors after an assessment.

When asked if this intervention should have still been in place for resident #002, PT #108 stated, that they should have continued to wear hip protectors as they often tried to self-transfer.

During an observation and interview with resident #002 and inspector #730, on a specified date, inspector #730 observed that the resident was not wearing hip protectors. When asked, the resident also stated that they were not wearing hip protectors.

On a specified date, inspector #730 asked Nursing Operations Supervisor (NOS) #106 to confirm whether or not resident #002 was wearing hip protectors while they sat in their wheelchair. NOS #106 wheeled the resident to their room and examined them. They returned a few minutes later and confirmed that they were not wearing hip protectors, but stated that they should have been as per their plan of care. [730]

B) The home submitted Critical Incident System (CIS) report #2655-000011-19 to the Ministry of Health and Long-Term Care (MOHLTC), on a specified date, which stated that resident #001 had an unwitnessed fall in their room two days prior. The resident was sent to hospital for assessment and was diagnosed with a fracture.

A review of resident #001's plan of care in PointClickCare (PCC), stated under interventions: "Hip Protectors."

On a specified date, at a specified time, resident #001 was observed not wearing hip protectors while in their wheelchair. At a later time, Inspector #745 observed that resident #001 was not wearing hip protectors while lying in bed.

On a specified date, at a specified time, Inspector #745 observed that resident #001 was not wearing hip protectors while sitting in their wheelchair. Inspector #745 observed resident #001 being transferred to bed by Personal Support Workers (PSWs). No hip protectors were applied to the resident after the transfer.

During an interview with PSWs #103 and #104, on a specified date, they stated that they were familiar with resident #001. PSW #103 stated that fall interventions for residents were listed in resident plans of care and that all staff had access to them. PSW #104 stated that resident #001 had specified interventions, as falls prevention interventions. When asked, the PSWs stated that they did not think that resident #001 wore hip protectors.

On a specified date, the Director of Resident Care (DRC) #102 reviewed resident #001's plan of care in PCC and confirmed that hip protectors were documented in resident #001's plan of care and Kardex. DRC #102 stated that if resident #001's plan of care showed hip protectors then the resident should have had and worn hip protectors.

During an interview, Registered Nurse (RN) #109 stated that they were the Falls Lead in the home. They stated that the use of hip protectors was not documented on a day to day basis but registered staff should have documented in the progress notes if a resident refused them. RN #109 also stated that resident #001 had hip protectors as a falls intervention in their plan of care, and confirmed that hip protectors should have been used for the resident as per their plan of care. [745]

C) The clinical records for resident #003 were reviewed in PointClickCare (PCC) and showed that the resident had an unwitnessed fall on a specified date.

The plan of care for resident #003 was reviewed in PCC and showed that the resident had a focus of falls related to wandering, following others, removing shoes, unsteady gait and that they would not use their walker. The plan of care showed documented interventions which included the use of hip protectors.

On a specified date, resident #003 was observed sitting in a recliner chair watching television. The resident was observed to be sitting independently and not wearing hip protectors.

During an interview, Registered Practical Nurse (RPN) #110 stated that they were familiar with resident #003 and that they recently had a fall. The RPN stated that interventions related to falls would be identified within the resident's plan of care or Kardex. When asked what interventions resident #003 had in place related to falls, RPN #110 reviewed the resident's plan of care in PCC and confirmed that they had hip protectors in their plan of care. The RPN stated that they believed that the resident took them off. Inspector #689 and RPN #110 observed resident #003 and the RPN stated that the resident was not wearing hip protectors. When asked if the resident had hip protectors available to be used, the inspector and RPN observed the resident's bedroom and they stated that they could not locate the hip protectors and they were not in the resident's bedroom.

During an interview, Registered Nurse (RN) #109 stated that all staff on the unit discussed and assessed whether falls interventions were effective for a resident. When asked who updated the residents' plans of care related to falls interventions, RN #109 stated that they or the RNs on the unit would and that they, the RN, the RPN, or the nursing clerk were responsible for ensuring that the resident had their interventions in place. RN #109 stated that they were familiar with resident #003, and that they had a fall recently. When asked what interventions the resident had in place related to falls, they stated the resident wandered a lot and took off their shoes. Inspector #689 and RN #109 reviewed resident #003's plan of care in PCC related to falls interventions and stated that the resident was resistive to having hip protectors on, but as per their plan of care the interventions were up to date and the hip protectors were a current intervention for the resident. The inspector informed the RN that they observed the resident on multiple occasions not wearing their hip protectors and that there were no hip protectors available in their bedroom. RN #109 stated that they would expect that the resident would be wearing hip protectors as specified in the plan of care. [689]

The licensee has failed to ensure that residents #001, #002, and #003 were wearing hip protectors as specified in their plans of care. [s. 6. (7)]

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

The home submitted Critical Incident System (CIS) report #2636-000052-18 to the Ministry of Health and Long-Term Care, on a specified date, which stated that resident #002 had an unwitnessed fall on a specified date. The resident was sent to hospital and was diagnosed with a fracture.

A review of the progress notes in PointClickCare (PCC) for resident #002 showed a "Physician Visit Note Late Entry" on a specified date, which stated that there was a plan for a specified intervention for resident #002.

A review of resident #002's paper chart, included a document titled "Emergency Record," with a specified date, which listed the same intervention under the discharge section.

A review of resident #002's plan of care, in PCC, did not list the specified intervention as an intervention.

Inspector #730 observed that resident #002 had the specified intervention in place.

During an interview, PSW #105, they stated that were familiar with resident #002, and that the specified intervention was in place after their fall the previous month.

Review of an assessment in PCC, for resident #002, titled "REHAB- PT Referral- V 2" stated that the specified intervention was in place.

During an interview with Physiotherapist (PT) #108 stated that resident #002 used the specified intervention for their fracture. PT #108 stated that the intervention was put in place by the hospital and they would have expected that the nursing staff would have added this to the resident's plan of care upon readmission, as it was a change from their baseline. After a review of resident #002's plan of care PT #108 stated that the specified intervention was not documented in the plan of care.

During an interview with Nursing Operations Supervisor (NOS) #106 stated that they would expect that the specified intervention should have been documented in the resident's plan of care in PCC. After review of the plan of care, the NOS noted that the intervention was not documented in resident #002's plan of care.

The licensee has failed to ensure that the plan of care was revised when resident #002's care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

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

Issued on this 1st day of April, 2019

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHRISTINA LEGOUFFE (730), CASSANDRA ALEKSIC (689), CHERYL MCFADDEN (745)
Inspection No. / No de l'inspection :	2019_790730_0005
Log No. / No de registre :	003066-19, 003631-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 29, 2019
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
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

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

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.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 6. (7) of the LTCHA.

Specifically the licensee must:
a) Ensure that the care set out in the plan of care related to falls prevention is provided to residents #001, #002, #003, and all other residents as specified in the plan.

b) Ensure a monitoring process is developed and fully implemented, including the staff responsible for monitoring, to ensure that the plan of care for residents at moderate or high risk for falls are being provided to the residents as specified in their plan. This monitoring process must be documented.

Grounds / Motifs :

1. 1. 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.

A) The home submitted Critical Incident System (CIS) report #2636-000052-18 to the Ministry of Health and Long-Term Care (MOHLTC), which stated that resident #002 had an unwitnessed fall on a specified date. The resident was sent to hospital to be assessed and was diagnosed with a fracture.

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(POA) the previous week for hip protectors to reduce hip injury.

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During an observation and interview with resident #002 and inspector #730 on a specified date, inspector #730 observed that the resident was not wearing hip protectors. When asked, the resident also stated that they were not wearing hip protectors.

On a specified date, inspector #730 asked Nursing Operations Supervisor (NOS) #106 to confirm whether or not resident #002 was wearing hip protectors while they sat in their wheelchair. NOS #106 wheeled the resident to their room and examined them. They returned a few minutes later and confirmed that they were not wearing hip protectors, but stated that they should have been as per their plan of care. [730]

B) The home submitted Critical Incident System (CIS) report #2655-000011-19 to the Ministry of Health and Long-Term Care (MOHLTC), on a specified date, which stated that resident #001 had an unwitnessed fall in their room two days prior. The resident was sent to hospital for assessment and was diagnosed with a fracture.

A review of resident #001's plan of care in PointClickCare (PCC), stated under interventions: "Hip Protectors."

On a specified date, at a specified time, resident #001 was observed not

wearing hip protectors while in their wheelchair. At a later time, Inspector #745 observed that resident #001 was not wearing hip protectors while lying in bed.

On a specified date, at a specified time, Inspector #745 observed that resident #001 was not wearing hip protectors while sitting in their wheelchair. Inspector #745 observed resident #001 being transferred to bed by Personal Support Workers (PSWs). No hip protectors were applied to the resident after the transfer.

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On a specified date, the Director of Resident Care (DRC) #102 reviewed resident #001's plan of care in PCC and confirmed that hip protectors were documented in resident #001's plan of care and Kardex. DRC #102 stated that if resident #001's plan of care showed hip protectors then the resident should have had and worn hip protectors.

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showed documented interventions which included the use of hip protectors.

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The licensee has failed to ensure that residents #001, #002, and #003 were wearing hip protectors as specified in their plans of care. [s. 6. (7)]

The severity of this issue was determined to be a level 2 as there was potential for actual risk. The scope of the issue was a level 3 as it related to 3 out of 3 residents reviewed. The home had a level 3 history as they had one or more related non-compliance with the LTCHA in the last 36 months that included:

- Written Notification (WN) and Voluntary Plan of Correction (VPC) issued June 28, 2017 (2017_262630_0015).
(730)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 06, 2019

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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

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

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 29th day of March, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Christina Legouffe

Service Area Office /
Bureau régional de services : London Service Area Office