Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 4, 2019	2019_797740_0020	011754-19, 013823-19, 015386-19, 016114-19	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 3) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
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

SAMANTHA PERRY (740), 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): August 26th, 27th, 28th, 29th and 30th, 2019.

The following intakes were completed within the Critical Incident Systems inspection:
Log# 015386-19 / CI# 2655-000045-19 related to falls prevention;
Log# 016114-19 / CI# 2655-000048-19 also related to falls prevention;
Log# 013823-19 / CI# 2655-000044-19 related to responsive behaviours and
Log# 011754-19 / CI# 2655-000039-19 also related to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Nurses, Registered Practical Nurses and Personal Support Workers.

The inspector(s) also made observations and reviewed residents' clinical records.

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

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

The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care (MOLTC) on a specific date. The home reported that an identified resident had a fall and was found without required falls interventions in place.
A review of the identified resident's clinical records, documented a room assessment was completed and several contributing factors to the resident's fall were identified.
The Director of Care (DOC) stated in part, that the required falls interventions should have been checked and verified to be in working order by staff before leaving the identified resident's room.

The licensee failed to provide the care set out in the plan of care as specified in the plan. [2007, c. 8, s. 6 (7).] [s. 6. (7)]

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

The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care (MOLTC). The home reported that an identified resident had a fall, resulting in a fracture.
A review of an identified resident's clinical record, documented on a specific date that a transfer pole be used for transfers in and out of bed; however, according to a physiotherapy note, the recommended transfer aid was a mechanical lift.
The DOC stated in part, that the identified resident's clinical record should have been revised when the resident's care needs changed, so that the plan of care accurately reflected the resident's transfer needs.

The licensee failed to revise the plan of care when the resident's care needs changed. [2007, c. 8, s. 6 (10)(b).] [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 with providing care as set out in the plan of care to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 5th day of September, 2019

[redacted]

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

Original report signed by the inspector.