Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 15, 2020	2020_648741_0012	016248-20	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

AYESHA SARATHY (741)

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): September 8 and 9, 2020

The following Critical Incident System (CIS) was inspected as a part of this inspection:

2655-000034-20 related to resident to resident physical abuse

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), the Behavioural Supports Ontario-Registered Nurse (BSO-RN), a Director of Resident Care (DRC) and a resident.

The Inspector also reviewed relevant policies and procedures, resident clinical records and observed identified residents.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in a resident's plan of care related to responsive behaviours was documented.

A Dementia Observation System (DOS) was initiated for close monitoring of a resident after one of their medications was adjusted related to an increase in responsive behaviours. The DOS required staff to complete 30-minute checks on the resident for five days. Upon review of the DOS, Inspector #741 noted missing documentation on four of 14 shifts.

The Behavioural Supports Ontario-Registered Nurse (BSO-RN) said when they reviewed the DOS after five days to look for behaviour patterns, it was incomplete and they were unable to determine whether the resident needed new interventions to manage their responsive behaviours.

The Director of Resident Care (DRC) said that the DOS for the resident was incomplete and should have been completed on every shift.

Sources: resident's progress notes and DOS charting, and interviews with the BSO RN, the DRC and other staff. [s. 6. (9) 1.]

2. The licensee has failed to ensure that the care set out in a resident's plan of care related to responsive behaviours was documented.

A DOS was initiated for close monitoring of a resident due to an increase in exit seeking behaviours. The DOS was reviewed by Inspector #741 and noted that the required documentation of 30-minute checks on the resident was incomplete for 14 out of 40 shifts.

The DRC said that the DOS for the resident was incomplete and should have been completed on every shift.

Sources: the resident's progress notes and DOS charting, and interviews with the DRC and other staff. [s. 6. (9) 1.]

3. The licensee has failed to ensure that the care set out in resident's plan of care related to responsive behaviours was documented.

A DOS was initiated for close monitoring of a resident for agitation, pain and discomfort

related to a fall the resident had sustained. The DOS was initiated with specific instructions for staff regarding the frequency at which the resident was to be monitored. The DOS was reviewed by Inspector #741 and noted that the documentation of the required checks was incomplete for 6 out of 13 shifts.

The DRC said that the DOS for the resident was incomplete and should have been completed on every shift.

Sources: the resident's progress notes and DOS charting, and interviews with the DRC and other staff. [s. 6. (9) 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 provision of the care set out in the plan of care are documented, to be implemented voluntarily.

Issued on this 16th day of September, 2020

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

Original report signed by the inspector.