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
May 7, 2021	2021_648741_0012	002378-21	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), CHRISTINA LEGOUFFE (730)

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): April 19-23, 26 and 27, 2021

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

CIS #2655-000007-21 related to an injury with an unknown cause that resulted in a significant change in health condition

An Infection Prevention and Control (IPAC) Assessment was also conducted as a part of this inspection.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), a Registered Nurse (RN), a Housekeeper, a Recreation Aide, a Public Health Inspector (PHI), an Assistant Director of Care (ADOC) and the Director of Resident Care (DRC).

As a part of the inspection, the Inspectors also reviewed relevant policies and procedures, clinical records of residents, and made observations of residents and IPAC practices in the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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 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):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed within one business day when a resident sustained an injury and had a significant change in their health condition.

A resident was sent to the hospital after complaining of pain in a specific area of their body. The same day, a physician at the hospital informed the home that the resident had a significant injury and would be offered treatment. The home submitted a Critical Incident System (CIS) report one business day late for this incident.

The Director of Resident Care (DRC) said that they were aware of the required timeline for reporting critical incidents to the Ministry of Long-Term Care and that this incident was reported late.

Sources: CIS report; the resident's progress notes; interview with DRC. [s. 107. (3) 4.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program related to the use of personal protective equipment (PPE) for a resident and droplet and contact signage for three residents.

Inspectors #730 and #741 observed that three residents had bags of PPE on the doors of their rooms, however no signage was posted related to contact or droplet precautions. A Registered Nurse (RN), Personal Support Worker (PSW), and a recreation staff said that the residents were currently on contact and droplet precautions and that the appropriate signage was not in place for them.

Inspector #730 observed a PSW in a resident's room without appropriate PPE on. Signage was posted on the resident’s door to indicate that they were under contact and droplet precautions. The PSW told Inspector #730 that the resident was under droplet and contact precautions and that they should have donned a gown and gloves, in addition to their mask and eye protection, when they entered the resident’s room, but did not.

The home’s policy said that droplet precaution signage was to be posted at the resident’s room doorway and that any staff within two metres of a resident under droplet precautions were required to wear the appropriate PPE.

There was increased risk to residents as a result of droplet and contact precaution signage not being posted and staff not donning the appropriate PPE.

Sources: The home's "Droplet Precautions" policy (last updated October 2019), observations of residents, clinical records for residents including census information and progress notes, and interviews with PSWs, an RN, recreation staff and other staff. [s. 229. (4)]

Issued on this 11th day of May, 2021

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

Original report signed by the inspector.