Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: October 20, 2023
Inspection Number: 2023-1161-0005
Inspection Type: Complaint Critical Incident
Licensee: CVH (No. 3) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)
Long Term Care Home and City: Chelsey Park, London

Lead Inspector	**Inspector Digital Signature**
Leah Carrier (000748)	Leah N Carrier Digitally signed by Leah N Carrier Date: 2023.10.20 13:34:39 -04'00'

Additional Inspector(s)
Ali Nasser (523)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 4, 5, 6, 10, 11, 12, 13, 2023.

The following Critical Incident (CI) intakes were inspected:

- Intake #00097870 [CI #2655-000028-23] related to Infection Prevention and Control
- Intake #00097969 [CI #2655-000029-23] related to Falls Prevention and Management

The following Complaint intakes were inspected:

- Intake #00094184 Complaint related to Resident Care and Support Services and Medication Management
- Intake #00094668 Complaint related to Resident Care and Support Services
- Intake #00095077 Complaint related to Prevention of Abuse and Neglect

The following intakes were also completed:

- Intakes #00098359 [IL-18127-AH], #00097548 [Critical Incident #2655-000027-23], #00092587 [Critical Incident #2655-000016-23], #00096899 [Critical Incident #2655-000026-2023] related to Falls Prevention and Management

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)

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

Rational and Summary:
The home submitted a report related to an incident resulting in a significant change in health status to the resident.

In the resident's admission assessment progress note, the resident was identified as high risk for falls and various falls interventions were recommended. Clinical record review for the resident showed their 24-hour admission care plan and resident care indicators did not include any direction related to their falls prevention interventions specific to their recommended interventions.

The staff that completed the resident's admission assessment confirmed the resident was high risk for falls and identified the resident's specific interventions related to falls prevention. They confirmed that those interventions were implemented on admission, but the admission 24-hour plan of care and the resident care indicators were not updated based on the assessment and the needs of the resident.

In interview with management, they confirmed that the resident's plan of care was not based on the assessment of the resident's care needs.

There was a risk to the resident when their plan of care related to falls prevention intervention was not based on an assessment and the needs and preferences of the resident.

Sources: clinical record reviews and staff interviews.
[523]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, 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.

Rationale and Summary
A complaint was submitted to the Ministry of Long-Term Care regarding resident care and support services. The resident's plan of care included specific directions related to monitoring the resident. Upon review of the resident's progress notes, several monitoring entries were not documented on various dates. In interview with a Registered Nurse (RN), they reported that it is the responsibility of registered staff members to document the monitoring in the progress notes. In interview with management, they confirmed that, even if the resident were to provide care independently, staff would still be expected to document this monitoring as per the plan of care.

Sources: Clinical record review, staff interviews
[000748]

WRITTEN NOTIFICATION: Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of the care set out in the resident's plan of care were documented.

Rational and Summary:
The home submitted a report related to a resident's fall resulting in a significant change to their health status. It was identified in the resident's admission assessment that the resident was high risk for falls and their falls prevention included specific interventions.

Clinical record review for the resident showed the resident care indicators and daily flow sheet had no documentation of those interventions. Management stated there was no documentation for the provisions of care set out in the resident's plan of care.

Management reviewed the resident's clinical record and said the provisions of care set out in the plan of care for the resident were not documented. They reported that the home had identified concerns related care plans and documentation. The home was working to ensure all plan of cares are completed and care would be documented.

There was a risk to the resident when the provisions of care were not documented.

Sources: clinical record reviews and staff interviews
[523]

WRITTEN NOTIFICATION: Windows

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 19

The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents could not be opened more than 15 centimeters.

Rational and Summary:
During the inspection it was noted that the windows in two rooms opened to the outside greater than 15 centimeters.

Management confirmed the windows in those rooms opened greater than 15 centimeters. They reported they would install brackets and screws to limit the windows from opening to the outside greater than 15 centimeters.

Sources: observations and staff interviews
[523]

WRITTEN NOTIFICATION: 24-hour admission care plan

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (1)

The licensee has failed to ensure that a 24-hour admission care plan was developed for the resident and communicated to direct care staff within 24 hours of the resident's admission to the home.

Rational and Summary:
The Ministry of Long-Term Care received a complaint related to resident care concerns. A clinical record review showed no documentation that the 24-hour admission care plan was developed for the resident.

In an interview with management, they confirmed the 24-hour admission care plan was not completed. They reported that the home had already identified this concern and stated that they updated their procedures and assigned staff to ensure plans of care were completed.

The resident was at risk when their 24-hour admission care plan was not developed and communicated to direct care staff.

Sources: clinical record review and staff interviews
[523]

WRITTEN NOTIFICATION: 24-hour admission care plan

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (2) 1.

The licensee has failed to ensure the 24-hour admission care plan included, at a minimum, any risks the resident might pose to themselves including any risk of falling and interventions to mitigate those risks.

Rational and Summary:
The home submitted a report related to a resident's fall resulting in a significant change to their health status.

In an interview with management, they stated that they completed a 24-hour admission plan of care for the resident. Upon review of the 24-hour admission plan of care, the falls section of the plan of care indicated the resident had recent fall. The care plan did not include any interventions for falls prevention.

Management reviewed the resident's clinical record and said the 24-hour admission plan of care did not include interventions to mitigate the risk for falling.

There was a risk to the resident when 24-hour admission plan of care did not include interventions to mitigate risk of falling.

Sources: clinical record reviews and staff interviews
[523]

WRITTEN NOTIFICATION: 24-hour admission care plan

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (4)

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

Rational and Summary:
The Ministry of Long-Term Care received a complaint regarding resident care and support services.

In an interview a RN, they said they completed the admission assessment for the resident. The RN stated that the resident and their family members requested specific clothing and dining options based on the preferences of the resident. A clinical record review showed a care plan intervention that included the specific requests of the resident and their family was added several days after the resident's date of admission.

In an interview management, they said the care plan should have been developed based on the resident preferences and if there were any risk or safety concerns, discussions should have been facilitated with the resident and their family. Management stated that the resident’s preference should have been in the care plan on admission day, and the resident's needs and preferences related to dining should have been respected. Management also stated that support and supervision should have been provided to ensure resident was safe.

The resident was at risk when their care plan was not based on their needs and preferences.

Sources: clinical record reviews and staff interviews

[523]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control (IPAC).

Rationale and Summary
A) The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes stated the following:
9.1 The licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include:
b) Hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact);
d) Proper use of personal protective equipment (PPE), including appropriate selection, application, removal, and disposal.

During IPAC observations, a Personal Support Worker (PSW) attended at a resident room to provide care to a resident. When the PSW exited the resident room, the PSW did not doff their PPE, and did not perform hand hygiene following resident and resident environment contact. Inspector #000748 did then observe the PSW touch the handles of another resident's wheelchair with the same gloves used to provide care to the previous resident.

Southbridge Health Care Policy No. 3.1 "Hand Hygiene," last revised April 13, 2023, identified that there are four moments of hand hygiene, with the fourth being after resident and resident environmental contact, including but not limited to, removing any piece of PPE; touching a resident or leaving a patient's environment; and after handling resident care equipment. In interview with a Registered Practical Nurse (RPN), they reported that hand hygiene must be completed when you leave a resident's room, and before and after donning and doffing PPE.

Sources: Observations; staff interviews; record review of Southbridge Health Care Hand Hygiene Policy [000748]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

The licensee had failed to ensure that the Director was informed of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition; no later than one business day after the occurrence of the incident.

Rational and Summary:
The home submitted a report related to a resident's fall resulting in a significant change to their health status, several days after the incident occurred.

In an interview with management that included a clinical record review of the resident's progress notes and assessments completed after the fall, they indicated the resident had a significant change in their health condition.

Management stated the resident had a significant change in their condition post fall, and that the CIS should have been submitted on the day that the significant change in the resident's health status was identified.

Sources: clinical record and staff interviews
[523]

WRITTEN NOTIFICATION: Medication management system

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

The licensee has failed to ensure that the written policies and protocols for the medication management system were implemented.

Rational and Summary:
The Ministry of Long-Term Care received a complaint related to medication management, including care related to specific treatments.

A review of the home's policy identified procedures that included documenting the initiation of a treatment on the physician/nurse practitioners (NP) orders, the resident's electronic medication administration record (EMAR), the resident's electronic treatment administration record (ETAR), and

progress notes. The policy also identified that, with specific treatments, care is to be provided at specific intervals, or as required.

A clinical record review showed that the resident was started on a specific therapy. Further clinical record review showed no documentation in the resident's EMAR and ETAR related to the administered therapy, and no documentation in the Kardex or flow sheets related to care provided to the resident related to the administered therapy.

In an interview with management, they stated the policy was not implemented by the staff, and reported that it was expected that the implementation of this therapy be documented in the EMAR and ETAR, in the Kardex and flow sheets, and that staff would document the care provided to the resident specific to the therapy.

The resident was at risk when the home's policy and procedures related to the specific therapy was not implemented by the staff.

Sources: clinical record reviews and staff interviews
[523]

WRITTEN NOTIFICATION: Medical directives and orders — drugs

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 126 (b)

The licensee has failed to ensure that no medical directive or order for the administration of a drug to the resident was used unless it was individualized to the resident’s condition and needs.

Rational and Summary:
The Ministry of Long-Term Care received a complaint related to the administration of a specific therapy to a resident.

A clinical record review showed that the resident was started on a specific therapy several days after their admission to the home. In an interview a physician, they confirmed the resident was started on the therapy. They stated that it was a drug, and it was started as per orders in the medical directive and that staff would inform the physician. The physician noted that the medical directive for the resident was not signed by them.

In an interview with management, they said the medical directive for the resident was not signed or individualized for each resident as that was not part of their process. Management stated they would be

changing the process in the home so staff review the medical directive and ensure they were individualized for the resident and signed by the physician.

There was a risk to the resident by not having the medical directive or orders individualized to the resident's condition and needs.

Sources: clinical record review and staff interviews
[523]

COMPLIANCE ORDER CO # Administration of drugs

NC # Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The inspector is ordering the licensee to comply with a Compliance Order [O. Reg. 246/22 s. 140 (2):

The licensee shall:
A) Review and revise as needed the home's process to ensure that medications are administered in accordance with the directions for use specified by the prescriber and direction provided by the pharmacy on the electronic medication administration records (EMAR), specifically related to crushing pills. A documented record of the review and revision must be maintained and included within the home's medication administration policies and/or procedures.

B) Registered nursing staff, including registered agency staff are to review the process in part A) to ensure that residents are administered medications as prescribed. The home must maintain a written record of the review which includes who participated in the review, the date the review was conducted.

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

Rational and Summary:
The Ministry of Long-Term Care received a complaint related to medication administration.

A clinical record review showed physician orders on the date of the resident's admission for medications with no direction for pills to be crushed. A clinical record review showed EMAR documentation that included medications with direction to staff: "Do Not Crush" and direction for a specific medication: "Do Not Crush, Hazardous, Do Not Crush."

In an interview the physician, they reported that they did not order the medication to be crushed, and that those specific medication should not have been crushed as per order and direction from pharmacy.

In an interview management, they stated the drugs should not have been crushed for the resident. The drugs were not administered in accordance with the directions for use specified by the prescriber.

The resident was at risk by having their pills crushed and drugs not administered in accordance with the directions for use specified by the prescriber.

Sources: clinical record review and staff interviews
[523]

This order must be complied with by November 30, 2023

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

A Compliance Order has been issued related to O. Reg. s. 140 (2) administration of drugs on March 31, 2023, as part of Inspection #2023-1161-0001.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.