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
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London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: September 25, 2024
Inspection Number: 2024-1161-0003
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 10, 12, 13, 16, 17, 2024.

The following intake(s) were inspected:

- Intake: #00120738 - Critical Incident System (CIS) report #2655-000037-24, related to the fall prevention and management program;
- Intake: #00123691 - Complaint related to concerns regarding resident care and the operation of the home;
- Intake: #00124204 - Complaint related to concerns regarding resident care and the operation of the home;
- Intake: #00124367 - CIS #2655-000045-24, related to a resident altercation.

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that all staff participated in the implementation of the home's Infection Prevention and Control (IPAC) Program when residents'

personal items were in a basket on the floor close to urinals and toilets.

Rationale and Summary:
During observations of multiple residents' rooms, it was observed in the bathrooms that residents' personal items were in an open basket placed on the floor under the sink beside plastic urinals and close to the toilets.

The Assistant Director of Care (ADOC) said the expectation was to place the personal items in the residents' closets. They said no items should be placed on the ground as this was an IPAC concern.

ADOC said the staff did not fully participate in the implementation of the home's IPAC program. ADOC ensured residents' personal items were moved and placed in accordance with the home's IPAC program and provided education to the nursing team regarding proper cleaning and storage of residents' personal care items.

Sources: observations, staff interviews.

Date Remedy Implemented: September 10, 2024

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that the care set out in the plan of care for a

resident was based on the needs and preferences of that resident.

Summary and Rationale:
A clinical record review for a resident documented incomplete and inconsistent provisions of the care and tasks required to ensure the resident's interventions were being completed consistently and/or there was no documentation in the plan of care at all.

An interview with the Director of Care (DOC) confirmed there were a lack of specific interventions and tasks set out in the resident's plan of care. This impacted the resident's right to receive specific care to support their care needs and therefore, increased their risk of a lack of care to consistently meet their needs.

Sources: Resident clinical record review, interview with management, and discussions with complainant.

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure the care set out in the plan of care for a resident was provided to the resident as specified in their plan of care.

Rational and Summary:

A clinical record review for a resident showed a specific intervention to be implemented by staff and was not.

In an interview the DOC said the specific intervention was not implemented by staff and should have been.

The resident was put at risk when the staff did not implement their specific intervention.

Sources: record reviews and staff interviews.

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
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.

The licensee has failed to ensure the provision of care set out in the plan of care for a resident was documented.

Rational and Summary:
A clinical record review for a resident showed a specific intervention was to be implemented by staff for all shifts and was not.

In an interview the DOC said the task should have been assigned for all the shifts and there should have been documentation by staff when completed.

There was a risk to the resident when the specific intervention was not included for all shifts.

Sources: record reviews and staff interviews.

WRITTEN NOTIFICATION: Complaints procedure - licensee

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure that when a written complaint was received regarding several care concerns, that alleged a risk of harm for a resident, that the complaint was immediately forwarded to the Director.

Rationale and summary:
A review of the Ministry of Long-Term Care complaint/response system showed there was no Critical Incident System (CIS) report submitted by the home.

An interview with the DOC confirmed the complaint alleged a risk of harm and was not immediately forwarded to the Director. This impacted the resident's right to legislative process and increased their risk for lack of care consistent with their needs.

Sources: Review of the complaint email, discussion with the complainant, review of the MLTC system and interviews with management.

WRITTEN NOTIFICATION: Dealing with complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that when they received a written complaint alleging a risk of harm for a resident, that the complaint was immediately investigated and a response to the complainant that complies with paragraph 3 of the legislation was completed.

Summary and Rationale:
A review of the home's records showed there was no written record kept in the home to support the home's compliance with paragraph 3, as set out by section 108 (1) 1. of the legislation.

An interview with the DOC confirmed they did not maintain a written record of the

complaint in the home. Furthermore, they acknowledged that the written complaint alleged a risk of harm for the resident, and they did not immediately investigate the complaint. This impacted the resident's right to legislative process and increased the resident's risk for a lack of care consistent with their needs.

Sources: The home's complaint binder, interview with management and discussions with the complainant.

WRITTEN NOTIFICATION: Reporting

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 2. iv.
Reports re critical incidents
s. 115 (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 (5):
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
iv. flooding.

The licensee has failed to inform the Director of a flood in the home that affected the safety of a resident for a period greater than 6 hours in no later than one business day after the occurrence of the incident.

Rationale and summary:
In an interview the Environmental Services Manager (ESM) said there was a flood, that impacted a resident.

In an interview the DOC confirmed the home experienced a flood and that it had

impacted a resident's safety. Therefore, the resident was relocated for a period of time. The DOC said they did not know they had to inform the Director or complete a CIS report related to the incident.

Sources: Staff interviews.

COMPLIANCE ORDER CO #001 Accommodation services

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 19 (2) (a)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with FLTCA, 2021, s. 19 (2) (a) [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:

Specifically, the licensee shall prepare, submit and implement a plan to maintain the home, furnishings and equipment and ensure they are kept clean and sanitary.

1. Completion of an audit of all the Resident Home Areas (RHA) to identify floors, walls, windowsills and other areas that need cleaning.

2. Completion of a checklist of the cleaning to be done which includes where, how, who would be responsible for completing the work, when the work will be started, when it will be completed and how it will be maintained as per the housekeeping procedures.

3. Ensure that the leadership team participates in creating the plan, including but not limited to the Administrator, Director of Care, and the Environmental Service Manager (ESM).

Grounds
The licensee failed to ensure the home, furnishings and equipment were kept clean and sanitary.

Rational and Summary:
Observations of several resident rooms showed dirt, dust and debris on the floor, behind the chairs in the rooms, under the beds, under the baseboard heaters and in the corners of the rooms. Some privacy curtains in resident rooms had multiple stains on them. Some window screens and windowsills had spider webs, dirt and dust build up.

Observations on the resident home areas including hallways and common areas by the nursing stations showed dirt, dust and debris on the floor and along the baseboards. Floors had visible stains on them.

Observations showed dirty cups placed on the hand rails in the hallways and on top of hampers by the dining rooms.

Observations completed with the Environmental Services Manager (ESM) of a sample of the resident rooms and common areas confirmed the rooms and common areas were not kept clean and sanitary.

When the licensee failed to ensure the furnishings and equipment were kept clean and sanitary it had the potential of impacting the residents' wellbeing and increased their risk for infection control concerns.

Sources: observations and staff interviews.

This order must be complied with by November 15, 2024

COMPLIANCE ORDER CO #002 Accommodation services

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with FLTCA, 2021, s. 19 (2) (c) [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:

Specifically, the licensee shall prepare, submit and implement a plan to maintain the home, furnishings and equipment to ensure they are kept in a safe condition and in a good state of repair.

A. Completion of an audit of all the RHAs including but not limited to; resident rooms/bathrooms, shower/tub rooms, dining rooms, common areas to identify rusty and corroded faucets, sink drains and plumbing fixtures, floors, walls, doors, doorways, handrails, base boards, door guards and other areas of disrepair.

B. Completion of a checklist of the work to be completed, which includes; where, how, who would be responsible for completing the work, when the work will begin, when it will be completed and how it will be maintained.

C. Ensure that the leadership team participates in creating the plan, including but not limited to the Administrator, DOC, and the ESM.

D. Conducting a review and revision as necessary to the preventative maintenance program to include regular audits of the maintenance of the home, furnishings and equipment to ensure they are kept in a safe condition and in a good state of repair. Keep a written record of this review, who participated, the date it occurred, and any changes made.

Grounds
The licensee has failed to ensure the home and furnishings were maintained in a safe condition and in a good state of repair.

Rational and Summary:
Observations in the home with the ESM showed some resident rooms with damage to walls, holes in walls and doors. Corrosion, rust and rust stains on the sinks, faucets and plumbing fixtures. Some rooms had the baseboard heater covers off and on the ground.

Some rooms had the vinyl baseboards peeling off the wall and other rooms had vinyl floor peeling off the floor.
Observations in the hallways showed the broken door frame guards including resident room doors, tub rooms doors and other common area doors, missing baseboards. Throughout the resident home areas scuffs and black markings on the walls were visible and multiple ceiling tiles were off.

The ESM said they were not familiar with the preventative maintenance procedures and audits had not been completed to ensure the home and furnishings were maintained in a safe and in a good state of repair. The licensee's failure to maintain the interior of the home in a safe condition and in a good state of repair had the potential of impacting the residents' rights to live in a safe, clean and comfortable environment.

Sources: observations and staff interviews.

This order must be complied with by November 15, 2024

COMPLIANCE ORDER CO #003 Doors in a home

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii. equipped with a door access control system that is kept on at all times, and
iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:

Ensure the door leading to a stairway on the main floor near the laundry and staff entrance is:
i. kept closed and locked,
ii. equipped with a door access control system that is kept on at all times, and
iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation.

Grounds
The licensee has failed to ensure that the door leading to a stairway on the ground floor near the laundry and the staff entrance was kept closed and locked, equipped with a door access control system and equipped with an audible door alarm.

Rationale and Summary:
The door leading to a stairway on the ground floor near the laundry and the staff entrance was observed to be unlocked and unattended. There was no keypad, lock or door alarm observed. There was a sign on the door stating, "staff area only" and several staff members were observed going through the doorway. Several residents were observed to be on the main floor.

In an interview the Administrator they said the home had been working with an installer, the fire department and the city of London to ensure proper permits were obtained to then install a keypad and attach the maglock to the fire panel.

The ESM said they were planning to start the installation within a few days and everything should be completed in a couple of days. In the mean time the home had a security guard at the door to ensure no resident would have access to the stairway.

Sources: observations, interviews and record reviews.

This order must be complied with by September 30, 2024

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

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.