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

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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
Jul 27, 2020	2020_598570_0005	006273-20, 009206-20, 009212-20, 009757-20	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 6) 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

Orchard Villa
1955 Valley Farm Road PICKERING ON L1V 3R6

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

SAMI JAROUR (570)

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): May 20, 21, 22, 25 - 29, 31, June 1 - 5, 7 - 12, 14 - 19, 21 - 26, 29, 2020.

The following Critical Incident Report (CIR) intakes were inspected upon during this Critical Incident System (CIS) Inspection:
A log #009212-20, related to a reportable incident.
Three logs #006273-20, #009206-20 and #009757-20 related to falls incidents.

PLEASE NOTE:
- Written Notifications and Compliance Orders (CO) related to LTCHA, 2007, c.8, s. 6. (4) (b) and s. 90. (2) (a) were identified in this inspection and have been issued in Inspection Report #2020_598570_0006, dated July 27, 2020.
- Written Notifications and Voluntary Plans of Correction (VPC) related to LTCHA, 2007, c.8, s. 6. (7), s. 8. (1) (b), s. 49. (2) and s. 52. (2) were identified in this inspection and have been issued in Inspection Report #2020_598570_0006, dated July 27, 2020.
- Written Notifications related to LTCHA, 2007, c.8, s. 38. (a), s. 89. (1) (a) (i) and s. 107. (4) 2. ii were identified in this inspection and have been issued in Inspection Report #2020_598570_0006, dated July 27, 2020.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Senior Executive Director (SED), Director of Care (DOC), Assistant Directors of Care (ADOC), Medical Doctors (MD), Registered Dietitians (RD), RAI-MDS coordinator, Clinical Consultant (CC), Food Service Manager (FSM), Environmental Services Supervisor (ESS), Infection Control Practitioner (ICP), Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapist (PT), Personal Support Workers (PSW), Family members and residents.

During the course of the inspection, the inspector(s) toured residents' home areas, conducted observations, reviewed clinical records and reviewed relevant policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the written plan of care for each resident, sets out the planned care for the resident.

A Critical Incident Report (CIR) was submitted to the Director regarding a fall incident involving resident #008. The CIR indicated that the resident was transferred to hospital and was diagnosed with an injury.

A review of clinical records for resident #008 indicated that the resident was at risk for falls.

A review of progress notes for resident #008 indicated that specified interventions were utilized for falls prevention.

A review of resident #008's written plan of care indicated that the specified interventions for falls prevention were not included in the written plan of care, until after the resident sustained a fall with an injury.

During separate interviews, PSW #137 and RN #146 indicated that resident #008 had interventions for falls prevention in place prior to the fall that resulted in an injury.

During separate interviews with the DOC, ADOC #145 and the RAI MDS Coordinator, they acknowledged that the use of specified interventions for falls prevention were not included in the written plan of care for resident #008, until after the resident sustained a fall with an injury.

The licensee did not ensure that the written plan of care for resident #008 set out the planned care for the resident, specific to falls prevention interventions. [s. 6. (1) (a)] (570)

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 written plan of care for each resident, sets out the planned care for the resident, to be implemented voluntarily.

Issued on this 30th day of July, 2020

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

Original report signed by the inspector.