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
Sep 8, 2020	2020_603194_0012	007361-20, 010064-20, 012460-20	Complaint

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

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 10, 11, 12, 13, 14, 17, 18 and 19, 2020

The complaint inspection included three logs related to personal care.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Nursing falls lead, Program Manager, Activation Staff, Environmental Service Supervisor (ESS) and Food Service Manager (FSM).

During the course of the inspection the inspector reviewed, clinical health records of identified residents, Food and Fluid records, Bathing records, Complaints Binders, Relevant policies related to Fall Prevention Management and Complaints and Customer Service. Observed resident rooms and call bell systems.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **2 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in different aspects of the care of resident #002 collaborated with each other in the assessment of the resident related to nutrition and hydration so that their assessments were integrated and were consisted.

A complaint letter from the Substitute Decision Maker (SDM) of resident #002 was received by the Director expressing concerns related to hydration and an ongoing medical condition resulting in hospitalization.

Review of the clinical health records indicated Resident #002 was provided two treatments for an ongoing medical condition within a one month period. Resident #002 was transferred and admitted to hospital.

The plan of care for resident #002 related to nutrition and hydration indicated that staff provided total assistance with all meals and nourishment. Resident #002 was to be provided a specified amount of fluid per day.

During review of the food and fluid intake records for resident #002, it was noted that the daily total fluid volumes during the reviewed period were below the goal range.

Interviews with PSW #110, #122, #123, #124, RPN #111, #107 and #118, all indicated that resident #002 required total assistance with all meals and nourishment and that PSW staff were to document food and fluid intakes in Point of Care (POC). PSW staff interviewed indicated that the documentation of the resident's care was not always completed, but that verbal reports related to intake and outputs for resident #002 would have been provided to the registered staff.

During interview with Inspector, RN #119 and DOC explained that the registered nursing staff were responsible for reviewing the food and fluid records. If there were changes in the resident's nutritional and fluid intake volumes an assessment would be initiated and/or dietary referral would be completed.

RN #126 indicated that they did not recall any concerns related to food and fluids for the resident #002. The progress notes for resident #002 indicated that RN #126 documented for a number of shifts, were the food and fluid records were below the goal range. RN #126 indicated that there were no referrals completed and does not recall having to complete any specific assessment for resident #002 related to hydration.

The FSM #125 indicated that the dietary assessment for resident #002 was completed remotely related to COVID. FSM #125 indicated that resident #002 did not have any previous intake concerns and no dietary referrals were completed for the resident. FSM #125 stated that the assessment would have included a review of the resident's intake records. FSM #125 was not aware that the food and fluid intake records were incomplete for resident #002 for the reviewed period, stating that the progress notes were reviewed, but no staff interviewed.

The licensee failed to ensure that registered staff and FSM collaborated with each other related to resident #002's nutritional and hydration status during the reviewed period. The food and fluid intake records were incomplete, FSM assessment indicated no change in condition when the resident had change in treatment for an ongoing medical condition.

An existing order was issued for this area of non compliance on July 27, 2020 Inspection #2020_598570_0006 with a compliance date of October 27, 2020. [s. 6. (4) (a)]

2. The licensee failed to ensure that the plan of care for resident #001 related to falls was provided as specified.

A complaint from SDM of resident #001 was received by the Director expressing concerns related to falls.

The clinical health record indicated resident #001 had numerous falls during the reviewed period. Post fall assessments for resident #001 were completed and the cause for falls were identified.

The plan of care for falls for resident #001 was reviewed and indicated that staff were to ensure that the call bell and commonly used items were within easy reach.

During interviews, PSW #110, #112, #113, RPN #108 and ADOC #102 have described Resident #001 as being able to stand unassisted but was not safe to transfer unassisted and did not recognize their limitations. RPN #120 was not available for interview.

Review of resident #001's progress notes indicated the following;

On a specific, date the progress notes and post fall assessment stated that resident #001 was reaching for their phone when they fell. The post fall assessment completed by RPN #120 indicated that the fall could have been prevented if the phone was within the resident's reach.

-On another date, the progress notes and post fall assessment stated that resident #001 was reaching to pick up the TV remote, at the time of the fall. During interview RPN #111 stated they had completed the post fall assessment and that during the post fall huddle, staff would have been reminded to ensure that personal items were within the residents reach.

-On another date, the progress notes and post fall assessment stated that resident #001 was trying to reach for the phone when they fell. RPN #118 completed the post fall assessment and indicated that strategies to prevent to fall included to ensure resident had all items required within reach.

The licensee failed to ensure that resident #001's plan of care related to falls was provided as specified when the residents items were not within easy reach or access

resulting in falls. [s. 6. (7)]

3. The licensee failed to ensure that when the resident #001 was reassessed for falls the resident's plan of care was revised, when the resident's care needs changed.

A complaint from SDM of resident #001 was received by the Director expressing concerns related to falls. The SDM indicated that resident #001 had numerous falls at the home.

During interviews PSW #110, #112, #113, RPN #108 and ADOC #102 described Resident #001 as being able to stand unassisted but was not safe to transfer unassisted and did not recognize their limitations.

The clinical health record indicated resident #001 had numerous falls during the reviewed period. Post fall assessment were completed where strategies were identified for resident #001 to prevent further potential falls, but plan of care was not updated and strategies were not implemented.

Review of the post fall assessment indicated that the resident sustained four falls, on separate occasions with strategies identified by registered staff.

During separate interview by Inspector #194 with RPN #107, #114 and #119, all indicated that interventions identified in the post fall assessments were not documented or implemented in the resident's plan of care.

Review of the plan of care for resident #001 was completed by Inspector #194. The strategies identified in the fall assessments were not noted in the plans of care reviewed. The plan of care identified that one of the fall strategies was initiated for resident #001 one month after being assessed.

The licensee failed to ensure that when resident #001 was reassessed for falls the resident's plan of care was revised, when the resident's care needs changed. [s. 6. (10) (b)]

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 by ensuring that resident's plan of care are provided as specified and when revised are update related to falls, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (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 to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written complaint received from the Substitute Decision Maker (SDM) of resident #001 was investigated and resolved within 10 business days.

The SDM of resident #001 express their concerns related difficulty to reach the home on an identified date. The complaint further expressed concerns related to manner in which staff provided information to the SDM and concerns related to safety of resident #001's personal belongings.

The SDM complaint was forwarded to MLTC by the interim ED.

The ED indicated that communication had been forward to the SDM by the Corporate office. The communication spoke to only one of the concerns expressed by the SDM. The ED verified that no further investigation into the concerns had been carried out by the home and the complaint did not receive any further communication from the home related to the identified complaint. [s. 101. (1) 1.]

Issued on this 17th day of September, 2020

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

Original report signed by the inspector.