

**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**

Central East Service Area Office  
33 King Street West, 4th Floor  
OSHAWA ON L1H 1A1  
Telephone: (905) 440-4190  
Facsimile: (905) 440-4111

Bureau régional de services de  
Centre-Est  
33, rue King Ouest, étage 4  
OSHAWA ON L1H 1A1  
Téléphone: (905) 440-4190  
Télécopieur: (905) 440-4111

**Public Copy/Copie du rapport public**

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Oct 28, 2020	2020_603194_0015	011886-20, 012153- 20, 015655-20	Critical Incident System

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**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

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**Long-Term Care Home/Foyer de soins de longue durée**

Orchard Villa  
1955 Valley Farm Road PICKERING ON L1V 3R6

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

CHANTAL LAFRENIERE (194)

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**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): September 21, 22, 23, 24, 25, 28, 29, 30, October 1, 5, 2020. October 6 and 7, 2020 were offsite.**

**Inspector completed:**

**Follow up inspection related to Order under O. Reg 79/10 s.90(2) with compliance date of August 27, 2020.**

**Critical Incident related to fall of a resident**

**Critical Incident for allegations of staff to resident abuse**

**During the course of the inspection, the inspector(s) spoke with Administrator, Assistant Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurse (RPN) and residents.**

**The inspector observed staff to resident interaction. The review of clinical health records of identified residents, abuse investigation notes, fall assessment records, relevant policy related to PASD's were completed.**

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

**Accommodation Services - Maintenance**

**Falls Prevention**

**Prevention of Abuse, Neglect and Retaliation**

**During the course of this inspection, Non-Compliances were issued.**

**1 WN(s)**

**0 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**

**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

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REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / DE L'INSPECTION	NO	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 90. (2)	CO #002	2020_598570_0006		194

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

Legend	Légende
<p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act**

**Specifically failed to comply with the following:**

**s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the Director was informed of the outcome of the abuse investigation.

A Critical Incident Report (CIR) was submitted to the Director for allegations of abuse of a resident a by PSW.

The resident reported to the RPN that two weeks prior a PSW had been abusive during care. The RN completed an assessment with no findings. The resident was interviewed by Inspector and was able to recall the incident, verifying information provided in the CIR. Review of the internal investigation was completed, where PSW denied the allegation of abuse. The Administrator stated the outcome of the internal investigation which was unfounded. The Director was not notified of the outcome of the abuse involving resident.

Sources: Internal abuse investigation notes, CIR, resident progress notes, interviews with ADOC, Administrator and other staff. [s. 23. (2)]

**Issued on this 29th day of October, 2020**

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

**Original report signed by the inspector.**